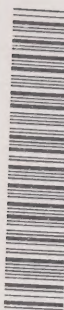


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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

HASTREITER

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

X McIntyre (cont'd)

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamak, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Scott

Transcript of evidence  
for

December 12, 1983

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Monday, the 12th day  
of December, 1983.

- - - - -

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

- - - - -

APPEARANCES:

P.S.A. LAMEK, Q.C.	Commission Counsel
D. HUNT ) L. CECCHETTO)	Counsel for the Attorney General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I.G. SCOTT, Q.C.) M. THOMSON ) R. BATTY )	Counsel for The Hospital for Sick Children
D. YOUNG	Counsel for The Metropolitan Toronto Police
W.N. ORTVED	Counsel for numerous Doctors at The Hospital for Sick Children
E. MCINTYRE	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

(Cont'd)










APPEARANCES: (Continued)

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
B. JACKMAN	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)



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Errata and Changes by Commission Staff:

Volume 73 - Thursday, December 1, 1983

Page 6087, line 20 - "high tissue level" should read  
"low tissue level"

Volume 74 - Friday, December 2, 1983

Page 6337, line 6 - "117" should read "1177"







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1/ak

1  
2 ---Upon commencing at 10:35 a.m.

3 DR. ALOIS RUDOLF HASTREITER, Resumed

4 THE COMMISSIONER: You are back.

5 MS. MCINTYRE: Yes, I am,  
6 Mr. Commissioner.

7 THE COMMISSIONER: I thought after-  
8 wards, I hope it wasn't, I hope it wasn't a good  
9 paying plan that you have abandoned.

10 MS. MCINTYRE: Gratuitously the  
11 matter in question resolved itself on Friday.

12 THE COMMISSIONER: That's good, all  
13 right. Yes, Mr. Lamek?

14 MR. LAMEK: Mr. Commissioner, just  
15 before Miss McIntyre continues with her cross-  
16 examination; I have had distributed this morning a  
17 copy of the report prepared by Dr. de Sa, who is the  
18 Pathologist from Winnipeg, who you will remember, sir,  
19 prepared  
20 /a separate report in conjunction with the Atlanta  
21 Epidemiological Study. I have recently obtained a  
22 copy of that separate report and had it reproduced  
23 and distributed.

24 I should say, sir, that I do not as  
25 presently inclined propose to call Dr. de Sa as a  
witness. If any counsel feels very strongly about  
his being called perhaps he can speak to me, but





1  
2 notwithstanding that may I offer his report as an  
3 exhibit so that it is before you, sir, and if it is  
4 necessary to supplement it by oral testimony from  
5 Dr. de Sa I will entertain that if anybody raises it.

6 THE COMMISSIONER: Yes. Exhibit 283.

7 ---EXHIBIT NO. 283: Report of Dr. D.J. de Sa.

8 THE COMMISSIONER: Yes, Miss McIntyre.

9 MS. McINTYRE: Yes, thank you,  
10 Mr. Commissioner.

11 CROSS-EXAMINATION BY MS. McINTYRE: (Continued)

12 Q. Dr. Hastreiter, I have given  
13 you this morning copies of the articles referred to  
14 in your case report Exhibit 276 that we were discuss-  
15 ing on Thursday afternoon. I take it those are the  
16 case studies referred to in Table 2 of page 486?

17 A. Right.

18 MS. McINTYRE: Perhaps,  
19 Mr. Commissioner, we could have those marked as  
20 exhibits.

21 THE COMMISSIONER: Yes, all right.

22 MS. McINTYRE: I have given copies  
23 to counsel as well as to the Registrar.

24 THE COMMISSIONER: Yes.

25 MR. LAMEK: Could we have them in







1

2

some particular sequence?

3

4

5

6

MS. McINTYRE: Well, the sequence that they are referred to in the table are the Steentoft Article first; perhaps if we could mark that 276A.

7

8

9

THE COMMISSIONER: That is a thought, we might mark them 276A, B, C and D in the order that they are.

10

11

MS. McINTYRE: Yes, in the order that they appear in the exhibit.

12

13

14

THE COMMISSIONER: Is Selesky the second?

15

16

MS. McINTYRE: Phillips is the second.

17

18

THE COMMISSIONER: Yes, right. Steentoft is the first, and Phillips is the third?

19

20

MS. McINTYRE: Dickson and Blazey is the third.

21

22

THE COMMISSIONER: And then Selesky is the fourth?

23

24

25

MS. McINTYRE: That is correct.

THE COMMISSIONER: Then we will make those Exhibits 276A to D.

---EXHIBIT NO. 276A: Extract "Fatal Digitalis Poisoning" by Anni Steentoft.







1  
2  
3 ---EXHIBIT NO. 276B: Excerpt "Case Experience  
4 with Digoxin Analysis of  
Post Mortem Blood" by  
A.P. Phillips.

5 ---EXHIBIT NO. 276C: Excerpt "Post Mortem Digoxin  
6 Levels - Two Unusual Case  
7 Reports" by S.J. Dickson and  
N.D. Blazey.

8 ---EXHIBIT NO. 276D: Excerpt "Digoxin Concentrations  
9 in Fatal Cases" by Maureene  
Selesky.

10 MS. McINTYRE: Q. Now, Dr. Hastreiter,  
11 you were indicating to me on Thursday that perhaps  
12 more information could be gleaned with respect to  
13 the time interval between administration and death  
14 by looking at the actual case studies themselves,  
15 and the ones that we were particularly interested  
16 in were the Phillips Study where there are time  
17 intervals of eight and six hours indicated; and the  
18 Selesky Study where you have indicated a time lapse  
of 5.5 hours.

19 Looking at the Phillips Study first,  
20 it would appear that the actual case studies do not  
21 provide us with much more information than you have  
set out in the table.

22 The first is Case No. 5 at page 138  
23 of the Phillips Study where it indicates:  
24  
25





1

2

"An 11-week old baby in Hospital was  
prescribed 0.05 -- "

3

4

THE COMMISSIONER: That is 276B is

5

it?

6

MS. McINTYRE: That is right.

7

Q. "An 11-week old baby in Hospital  
was prescribed 0.05 milligrams digoxin  
intravenously every four hours.

8

9

10

Immediately after the fourth dose had  
been administered, the nurse concerned  
realized that this had been tenfold

11

12

overdose. The baby died 8 hours later."

13

So that would indeed seem to be beyond

14

the peak at that time of the medication.

15

A. It is a long time interval,

16

yes.

17

Q. And there is not any further

18

information in there that would help us with respect  
to why there was such a long time delay?

19

A. No.

20

Q. And similarly with Case No. 11

21

referred to on page 139 it is indicated:

22

"A 2-month old baby in Hospital was

23

presecribed digoxin intravenously, but

24

the prescription stated 0.8 milligram

25







1

2

"doses instead of the intended 0.08  
milligrams. An hour after the first  
dose the child was seen to be in  
distress, and died six hours after  
injection."

3

4

5

6

7

Again that would seem to be well  
beyond the peak time or steady state of the medication.

8

A. That is correct.

9

10

Q. I see in the Phillips Study  
there is reference to two other children who also  
died of apparent digoxin overdoses, this time as a  
result of tablets which contained the wrong concentra-  
tions, Cases 3 and 4.

11

12

13

A. Yes.

14

15

Q. I take it you didn't include  
those in your case study and that they were not IV  
administrations?

16

17

A. I don't see how a two-month  
old baby could take tablets, I think it must be an  
error. The reason I didn't include it is because of  
the age difference, the children that take tablets  
were usually older children.

18

19

20

21

Q. You don't think Case 3 can be  
accurate?

22

23

A. I don't believe so unless they

24

25





1  
2  
3 have an area when they mention tablets and they  
4 possibly meant liquid solution of some kind which  
5 would be acceptable, but that would be the only case  
6 in the literature then of a little baby that died of  
7 overdose by mouth, because all the others are older  
8 children, they are beyond a year of age, to my  
9 knowledge.

10 Q. In any event it would appear  
11 that again there was significant time delay between  
12 the last administration and death, in that it  
13 indicates the child died on the next day.

14 A. Right.

15 Q. Now in the Dickson and Blazey  
16 case report - I take it from reading Case 1, which  
17 is the one you have referred to in your report  
18 dealing with a 10-week old baby in the Hospital,  
19 that the error was one of prescription in that it  
20 says:

21 "The baby showed improvement after the  
22 first 80 micrograms of pediatric  
23 digoxin and the doctor indicated  
24 verbally to the nursing staff that,  
25 for the child's comfort, later doses  
should be 80 micrograms of the adult  
formulation administered intramuscularly."







1  
2 And there again was a tenfold error overdosage given;  
3 but in that case there was not a significant time  
4 delay between the administration and death, it was  
5 20 minutes?

6 A. Yes, I would not call this  
7 an error in description, I think it is an error in  
8 dispensing the drug, because the prescription was  
9 appropriate 80 micrograms had been prescribed.

10 Q. Well, Doctor, it indicates  
11 that the adult formulation was 10 times as concentrated  
12 as a pediatric formulation.

13 A. Yes, but he or she still had  
14 prescribed 80 micrograms.

15 Q. So it was an error in calculation?

16 A. Yes.

17 Q. Thank you. The last one you  
18 referred to, the Selesky one where there was a very  
19 large dose of 3 micrograms given, and you have  
20 recorded the dose to death time interval as being  
21 5.5 hours. I take it that is Case No. 15?

22 A. Yes.

23 Q. Referred to on page 415 of  
24 that report?

25 A. Yes.





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Q. And here I gather that it was:

"A 3-day old child with congenital

heart disease was given a blood

exchange and administered 3.0 milli-

grams of digoxin at 12:45 p.m. ..."

And a further 1 milligram at 3:00 p.m., which was

significantly more than what the proper dose should

be and the child died at 6:10 p.m.

-----





B/BN/ko

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So I take it that there was a 5.5 hour interval between the first dose and death, but only about a 3 hour interval between the 1 milligram dose and death?

A. That is correct. I was taking the 3 milligram dose as the fatal one, although I am sure it is the sum of both.

Q. It would be a cumulative effect?

A. But the 3 milligram dose would be fatal also for a little baby like this. In fact, it is very difficult to really assume that such a large quantity was given. I wonder if they made an error in the report and they possibly meant 0.3 and 0.1 milligrams, but we do not know.

Q. In any event, from the facts that are reported, it would appear to be a 5.5 hour interval between the large 3 milligram dose and death, which again would be significantly beyond the peak effect of the digoxin?

A. Yes, beyond the reaching of the peak effect. Of course, the peak effect may continue for a while.

THE COMMISSIONER: Beyond the alpha peak certainly.

MS. MCINTYRE: Q. Beyond when the







1  
B 2 2 steady state was reached?

3 A. Yes. That is, the steady state  
4 has now been reached and we are in a steady state  
5 condition essentially.

6 MS. McINTYRE: Thank you, Doctor. I  
7 have no further questions.

8 THE COMMISSIONER: Mr. Scott?

9 CROSS-EXAMINATION BY MR. SCOTT:

10 Q. Dr. Hastreiter, I take it it  
11 goes without saying that the reputation of the  
12 cardiology service at Sick Children's in Toronto  
13 among its peers is among the highest in North America?

14 A. I would say it is among the  
15 highest in the world.

16 Q. Thank you. Do you know  
17 Dr. Richard Rowe?

18 A. Yes.

19 Q. Can you tell us how you would  
20 rank him as a pediatric cardiologist?

21 A. I think he is one of the most  
22 renowned and outstanding in the world.

23 Q. I have heard it said that he is  
24 one of the top two or three in the world; would you  
25 agree with that?

A. Yes.





1

B 3

2

Q. I take it that you know

3

Dr. Robert Freedom?

4

A. Yes.

5

Q. Now, he is a generation once

6

removed from Dr. Rowe, you and perhaps me, I grudgingly  
concede, but I take it at that generation he is

7

regarded as highly qualified?

8

A. Yes.

9

Q. And he has an international

10

reputation?

11

A. Yes.

12

Q. You were aware, or perhaps you

13

were not -- I should ask you -- were you aware that  
he participated in the autopsies with respect to most,  
if not all, of the cardiac cases that died in the  
Hospital for Sick Children?

14

15

16

A. I know that he has an appoint-

17

ment in pathology also and that he would review all  
the cases.

18

19

Q. Well, I note, just in passing,

20

that this report from Dr. deSa, who is the

21

Pathologist in Chief at the Children's Hospital in  
Winnipeg says that:

22

"Dr. Freedom is a senior cardiologist

23

with an international reputation for

24

25







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B 4

"his considerable expertise in the morphology in congenital heart disease."

MR. HUNT: What page is that on?

MR. SCOTT: Q. That is at page -- the pages are not numbered but it looks to be at page No. 7. Would you agree with that?

A. Yes.

Q. So I take it we can begin with the proposition that in scientific and clinical terms, the cardiac cases at The Hospital for Sick Children are well served and perhaps as well served as anywhere else in the world?

A. Yes.

Q. Now, I do not know if this ~~message~~ <sup>message</sup> got through to you, but Dr. Rowe gave evidence, and I asked him some questions in Volume 19 about the causes of cardiac arrest, and I want to know if you had occasion to read that, if you had the opportunity to read that?

A. Yes, I had.

Q. You will recall that he listed some 13 or 14 separate causes of cardiac arrest which are commonly found or which are found, from time to time, on a children's cardiac ward; do you recall that?





B.5

BN.  
jc

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A. Yes.

3

Q. And that he listed the extent

4

in each case to which those causes were accompanied

5

from time to time by bradycardia, a sudden terminal

6

event, fibrillation, arrhythmia, shallow respiration

7

and vomiting; do you recall that?

8

A. Yes.

9

Q. Do you have any complaint or

10

any point of disagreement about the evidence that

Dr. Rowe has given on that score?

11

A. No, except to say that each

12

one of these causes has to be interpreted within the

13

clinical setting in which it occurs, and it could,

14

of course, be very different, you know, in a different

setting.

15

Q. But each of them are poten-

16

tial causes, in theory, of cardiac arrest?

17

A. Yes.

18

Q. And it will be for the

19

clinician, by and large, with the assistance of the

20

record and his observation of the babies to judge

the appropriate cause?

21

A. Right.

22

Q. I take it it is no fault of

23

yours, and it happens all the time, that your review

24

25





B.6

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2

has necessarily been constrained to the written record?

3

A. Yes.

4

Q. When you were retained by the

5

Crown Attorney, did he give you any instructions

6

about discussing the matter with staff members at

7

The Hospital for Sick Children?

8

A. I do not remember that there

9

were -- I do not believe so, no.

10

Q. I take it for whatever reason,

11

and I have no complaint about it, it was decided

12

that it was inappropriate to do that for your

13

purposes?

14

A. At that time, yes.

15

Q. And I take it that your purposes

16

generally were to, I think you used this expression,

17

act as a kind of seive to separate out those cases

18

about which the cause of death, that is, a non-

19

malevolent cause of death, was clear and beyond doubt?

20

A. Yes.

21

Q. Leaving all the other cases to

22

be reviewed again not because they were necessarily

23

malevolent, but simply because beyond doubt and

24

clarity was not, in your judgment, present?

25

A. That is correct.

26

Q. Now, I think you said somewhere

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B.7

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in your evidence, and Mr. Hunt will go wild because I do not have a note of the page, but I think you said that in reviewing the records you found that there was, by and large, a high quality of record-keeping at The Hospital for Sick Children as those records revealed?

A. That is correct.

Q. Yes. Dr. DeSa says in his report at page No. 7, and perhaps I will just read this to you and see if you agree with it, and he looked at the autopsy reports, that was his job, and he said:

"I was impressed by the overall high quality of the autopsy reports." Would you accept that statement as your own or is that for a pathologist?

A. Yes, I think that is more for a pathologist to decide. My opinion as a clinician concurs with Dr. DeSa's.

Q. Yes. At page No. 8 he says, and he is reviewing 41 cases at autopsy, which is different, of course, than you did, and I am going to ask you to listen to this and see if you can relate it to simply the autopsy reports that you saw.





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"In the cases where a full autopsy was performed I was impressed furthermore by the fact that considerable attention had been paid to the macroscopic changes seen in other organs. This was particularly heartening and quite different from my experience at the autopsy reports from other hospitals on congenital heart disease cases. There is a tendency for the emphasis to be on the cardiac malformation and while understandable too often the changes present in other organs tend to be neglected or ignored. This is not the case as far as the autopsy reports from Hospital for Sick Children is concerned."

Do you agree generally with that observation with respect to the autopsy reports that you had occasion to read?

A. Yes.

Q. Thank you.

THE COMMISSIONER: Dr. deSa is an excellent man in everything except possibly grammar.





1  
C2 2 I don't know how that small "is" got in there some-  
3 where.

4 MR. SCOTT: You are quite right,  
5 Mr. Commissioner, but when these doctors were learning  
6 substantial stuff you and I were learning grammar.

7 Q. Now; in Volume 19, page 3435  
8 Dr. Rowe was asked about nursing notes, and let me  
9 just read to you what he said to see if you concur  
10 and, like you, he was quite often looking at the  
11 record and perhaps the record exclusively as you  
12 were. He is questioned at line 13, and we have had a  
13 lot of evidence -- Mr. Hunt I think is going to show  
14 it to you.

15 Do you want to show him the transcript,  
16 Mr. Hunt?

17 MR. HUNT: Well, we have been doing  
18 that with the witness, so I thought I would just  
19 continue.

20 MR. SCOTT: Fine.

21 MR. HUNT: What is the page number  
22 again?

23 MR. SCOTT: 3435, Volume 19.

24 THE WITNESS: Thank you very much.

25 MR. SCOTT: Q. At line 13:

"We have had a lot of evidence that







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the nurse's note indicates that  
Baby X is stable or nothing much  
has been happening for a day and then  
there is a cardiac arrest suddenly  
out of the blue in a stable course.

With respect to these 14 causes  
does that strike you as odd or  
unusual?"

And then Dr. Rowe says:

"A. I think that babies can appear  
to be stable when they are not  
really stable and they can certainly  
deteriorate, some of them, there is  
absolutely no question about that,  
but it depends...Not always, but it  
depends very frequently on observa-  
tion that is rather specialized in  
order to determine whether those  
babies are as stable as you might  
think prior to the deterioration.

That is because not everything  
that is under external observation by,  
say, a nurse or parent, would neces-  
sarily be sufficient guide to indicate  
a deteriorating, an infant who is





C4

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deteriorating who could appear  
stable on the outside."

And then one of my better questions:

"Q. Yes."

"A. And that is a difficult problem  
because it obviously - it would demand  
for the thing to be satisfied in terms  
of detection of that decay would be  
somebody who would be knowledgeable  
like the physician, pediatrician or  
cardiologist in this particular area,  
being able to make observations that  
are different from those that I have  
described by others."

Do you accept that as a general  
proposition?

A. Yes, I do, but I should also  
perhaps add that the nurses who care for this parti-  
cular type of baby are very well trained in general  
and in some ways they perhaps will detect the changes  
more so than the physicians because they are there  
continuously. Also, in other situations, the parent  
that is used to seeing the child every day will detect  
changes before the physician will. I have seen this  
happen on many occasions.





C5

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Q. But I take it that you would also agree with Dr. Rowe that the converse is true, that is to say, there may be conditions of stability observed by a parent or even a sophisticated nurse, that by the consulting pediatrician may reveal in fact there is not stability, but the commencement or the progress of a deterioration?

A. Yes, this can occur.

Q. Yes. Now, you gave at the request of the Crown Attorney I take it, a severity rating for each of these cases numbered 1 through 10?

A. Yes.

Q. And was that done at the request of the Crown Attorney or the police?

A. Yes.

Q. I take it that this is not something that you would normally do as a cardiologist in assessing your own patients or patients with whom you had been consulting?

A. No, I don't think I would ordinarily do this for an individual patient but I would do it for a study; if I had a study that I was conducting I would do it.

Q. And you would agree with me that the numbers you have assigned, while I have no







1  
C6 2 doubt very carefully chosen, present a relatively  
3 rough gauge as to severity in each case?

4 A. That is true. It is very  
5 difficult to estimate accurately the severity of each  
6 individual case.

7 Q. Anybody who has ever marked an  
8 exam paper and is restricted between 1 and 10 for the  
9 marks perhaps has the kind of assessment that you  
10 have to make, these babies had to be fitted in some-  
where in that range, didn't they?

11 A. True, yes.

12 Q. And I take it that you would  
13 not regard your numbers as fixed or inflexible and  
14 you would permit the possibility of variation either  
up or down?

15 A. Yes, if I could be convinced  
16 that this was the situation.

17 Q. All right. Well now, in making  
18 the number evaluations, Doctor, can you tell me what  
19 you considered? Did you consider the cardiac mal-  
20 formation where there was one?

21 A. Yes.

22 Q. Yes.

23 A. That was the prime factor,  
24 actually.

25 Q. Yes. I take it that in fact





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there was no significant other factor because in cases like Woodcock where there was liver trouble you gave Woodcock a 2 but were good enough to note in the margin that there was liver trouble.

A. Well, I don't quite completely agree with you there because I did try to take into consideration other factors. I think there were only two in whom I felt there was a significant factor other than the cardiovascular and I indicated them separately. But I did try and take these factors into consideration, yes.

Q. Well, I guess what I am asking you, if you look at Woodcock, for example, you say "2, also had liver disease".

A. Yes.

Q. Did the "2" include the liver disease or would you have to escalate that figure if you were to include the liver disease?

THE COMMISSIONER: Is that word, is it "disease" or "disorder"? It is your writing, Doctor, so I can ask you that.

MR. SCOTT: It is "dis" something.

MR. HUNT: It is Exhibit 281, Mr. Commissioner.

THE COMMISSIONER: Yes.





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MR. HUNT: I don't know if the witness has a copy.

MR. LAMEK: I have a copy.

THE WITNESS: Thank you very much.

MR. SCOTT: Q. Let me tell you the impression I got and you tell me if I am wrong.

A. Yes.

Q. I got the impression that the "2" alone in terms of severity would have been, if left alone, would have been misleading and that's why you put "also had liver disease" in brackets.

A. I think you are correct. The severity of the liver disease at the time represented a problem. It was difficult to grade I felt and I don't believe that it has been taken into consideration, at least not to a major degree.

Q. Now, you have been candid to say, and it is fair enough that you are not a liver expert, but if you were taking into account the liver disease and the cardiac condition both together, that is, trying to rate the severity of the patient rather than the cardiac disease, what number would you give to Woodcock?

A. Well, we are talking here about a rating of severity that could explain the baby's







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death. The liver disease could be rather severe but  
it would be unlikely in my opinion unless it were  
extremely severe and there were indications that this  
was already taking place that it would lead to death,  
therefore, I don't believe that my rating would be  
very different from what I have here.





D/DM/ak

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Q. All right. In fixing these

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numbers ---

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THE COMMISSIONER: Can I just

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interrupt to get this straight, that is, the word

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is "disease" is it that you wrote on 201?

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THE WITNESS: Yes, I am sorry, it

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is "disease".

9

MR. SCOTT: Q. Let me ask you some

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other questions about these numbers. In fixing these

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numbers did you consider and give any weight to the

presence of a non-cardiac anomaly?

12

A. Yes, whenever I could, and

13

whenever the situation was clear, there may have

14

been one or another situation where let's say the

15

final report was not available, or something of that

sort.

16

Q. But do I have it that you

17

tried to include non-cardiac anomalies as a considera-

18

tion in fixing on your numbers?

19

A. Yes.

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Q. Did you give any consideration

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to low birth weight in fixing your numbers?

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A. Yes.

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Q. Did you give any consideration

to the failure to thrive as evidence, if it was, by

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the clinical record?

A. Yes. The entire clinical course, of course failure to thrive, low birth weight are part of the clinical findings that one would have to take into consideration.

Q. Let's turn to one of them, the Baby Miller, and you rated the Baby Miller 5. Were you aware that - do you know Dr. Nadas from the Boston Hospital?

A. Yes.

Q. And he is a well respected cardiologist?

A. Yes.

Q. Were you aware that he had determined that the prognosis for this baby was "guarded"?

MR. HUNT: I'm sorry, what is it that you are referring to?

MR. SCOTT: To the Atlanta Report.

MR. HUNT: Perhaps the witness would like to have that.

THE WITNESS: Yes, I think maybe I should look at it.

MR. SCOTT: Q. It just says "guarded". If my friend wants to put it in front of





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him, it is 02065 is the number of the baby.

3

A. Thank you very much. Did you

4

say page 65?

5

Q. Again I don't have page numbers.

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THE COMMISSIONER: It is page 62,

7

I think, is that the one that starts "This one year  
old girl"?

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MR. SCOTT: No, it is a chart, it

9

is page 68, Mr. Commissioner.

10

Q. Dr. Nadas has rated this baby,

11

and just so you will know the number is 02065,

12

Dr. Hastreiter, which is just above the break in the  
page.

13

A. Yes.

14

Q. Dr. Nadas has reviewed the

15

record, or the summary of it, I am not quite clear

16

which, and listed the Miller baby as intermediate

17

in terms of clinical status on admission; the prognosis

18

"guarded"; the timing of death "unexpected but

19

consistent with clinical status", and I don't know

20

what this means, but "a higher level of care was

21

required".. Were you aware of that when you gave your  
number of 5 to the Miller baby?

22

A. No. I think in order to

23

analyze Dr. Nadas' report one would have to know

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exactly what these words mean.

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Q. Well, the definitions are

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contained elsewhere in the report.

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A. Yes.

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Q. You have not read the report.

7

A. Because I see that he labels

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all these babies as either "intermediate" or

9

"critical" except one, and that was "satisfactory".

10

That means that intermediate is really not a very  
bad rating in that sense.

11

Q. Is that the conclusion that you

12

draw?

13

A. Yes, from looking at it very

14

briefly, but I don't - he also rates the prognosis

15

as "poor" or "guarded", and guarded is better than

16

poor there I think, it is again a better category

17

than most of the other babies, so I don't think there

18

is a very basic disagreement.

19

Q. You think there is no basic

20

disagreement between you and Dr. Nadas?

21

A. Well, you know, this is

22

really the first time I am thinking about his grading

23

and I would need a little more information really to

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reach a better conclusion, but from what I have seen

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so far, no, I don't think there is.





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Q. Now, Dr. Rowe at Volume 18,  
page 3186 and 3187 reviews the condition of Allana  
Miller upon admission and says, at page 3187:

"That her case represents a fairly  
complex problem."

Would you agree with that assessment?

A. Yes.

Q. He also says at page 3189:

"That this child was noted to be  
developing pulmonary vascular disease  
which is unusual in a baby so young."

Would you agree with that assessment?

A. Yes. There was some evidence  
of that, but babies who have this type of lesion  
usually don't develop severe pulmonary vascular  
disease so early as he stated.

Q. Yes.

A. I don't have this information  
right in front of me, if I had the cardiac catheter-  
ization report I could tell you how severe it is,  
there are different grades of pulmonary vascular  
disease.

Q. And on a chart prepared for  
this Commission, Dr. Rowe gave evidence that the  
Miller baby exhibited a failure to thrive; would





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you agree with that?

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A. Yes, that is true of every baby who has severe heart disease and findings of congestive heart failure.

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Q. I should also tell you that at Volume 29, pages 5517-5518, Dr. Freedom says that the day before Baby Miller's death she was tugging and showing respiratory distress and exhibited a chaotic rhythm on the cardiogram, and he says:

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"I was still so concerned about her that I was not going to have her discharged before the surgery date."

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MR. HUNT: What page was that,

14

Mr. Scott, please?

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MR. SCOTT: 5517-5518 and it is at 5518 about one-third of the way down the page.

16

17

Q. Now, I want to ask you ---

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MR. HUNT: Perhaps the witness could have a moment to look at that.

19

MR. SCOTT: All right.

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Q. Were you aware, Doctor, you have read it now, were you aware that Dr. Rowe and Dr. Freedom had expressed those views about Baby Miller?

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A. No, I was not aware because

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those statements were made afterwards. I think from my analysis of Allana Miller's record there was no evidence of a chaotic rhythm on the electrocardiogram. I think that is a little bit - you could describe any irregular rhythm as chaotic. I don't think that there is a specific rhythm in cardiology which is called a chaotic rhythm.

Q. If I could just stop you there.

A. Yes.

Q. I take it you don't assert that Dr. Freedom would describe any rhythm as chaotic; I mean we are now not describing rhythms, we are almost describing motives. I take it you accept his opinion as being his own assessment at the time.

A. I would have to find out from him what his concept of a chaotic rhythm is, because I don't agree with him.

Q. Let me put this to you; you haven't had the advantage of reading the transcript; but having heard what Dr. Rowe has said and what Dr. Freedom has said about this child, is there anything there that permits you to reconsider the evaluation you have made with respect to the severity of Baby Miller's case?

A. No.





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Q. So that information has no impact on your judgment in terms of changing the 5 to some other figure?

A. No.

Q. All right.

A. I think, you know the type of infants we are dealing with here are all sick. I mean, I am the first one to concede this, but within this group and the range of severity of the clinical situations, I think I would keep my grading as accurate as I can make it.

Q. The point I am getting at, and just tell me if I have it right, that the information I have now provided you doesn't lead you to change your grade?

A. No.

Q. Or your assessment of the severity of this case?

A. No.

Q. Why is that?

A. Because I have read the record and I had knowledge of much of what has been said by Dr. Rowe and Freedom. I think the interpretation of certain facts may be a little bit different and I think there is always this possibility of,





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when different people look at the same case, because you don't have a minute to minute description and you have - you are dealing with observations of other people who may be good observers, or bad observers, and you have to interpret this information. I don't think Dr. Rowe himself cared for this baby personally, I don't think he saw the baby himself.

Q. No, but Dr. Freedom did.

A. Dr. Freedom did, yes.

Q. Are you not impressed by the observations of the clinician on this score?

A. Oh, I am impressed, I just ---

Q. I mean, it is no big deal.

A. Yes.

Q. But are you prepared to put that factor into the scale in assessing the severity of this case?

A. Oh, I certainly would take his evaluation of the baby into consideration, but even doing so I would retain my grade.

Q. I used to mark papers and have students who would come in with a 45 and they would try to get me up to 50, you must be a tough fellow to deal with in that context.

Let's take another case, let's deal





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with Baby Inwood; and the Baby Inwood is 02061 of  
Dr. Nadas' chart, and this baby is marked "critical",  
that is the clinical status of admission, and  
prognosis "poor".

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THE COMMISSIONER: I'm sorry, what  
page is this on again?

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MR. SCOTT: It is at 78 I think,  
sir.

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THE WITNESS: 68.

MR. SCOTT: I'm sorry, 68.

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THE COMMISSIONER: Yes, all right,  
68.

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THE WITNESS: What was the baby's  
code number again, I am sorry?

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MR. SCOTT: Q. 02061 it is three  
above Allana Miller.

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A. Yes.

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Q. And this baby is critical in the pre-epidemic period. There are only eight other babies that are listed as critical. Its prognosis is poor; the timing of death is unexpected but consistent with the physical symptoms. You were not aware of that when you gave your rating, were you?

A. No, I was not aware of his evaluation.

Q. Does that have any impact on you?

A. No.

THE COMMISSIONER: Strangely enough, though, that baby was one of the lower risk deaths from Dr. Rowe, I think, was it not?

MR. SCOTT: We will be coming to Dr. Rowe. Dr. Rowe indicated that this baby exhibited a failure to thrive.

THE COMMISSIONER: Yes. I found of all of Dr. Rowe's charts, the one not necessarily the most accurate but the easiest one for me to follow is the one at the end of Exhibit 127.

MR. SCOTT: Yes, I have that.

Q. And Dr. Rowe, at Volume 18, Page 3087 says this:

"The echocardiogram was reported as





showing aortic stenosis and a possible  
atrium septal defect, only a verbal  
report."

Then a quote from the report, and I think this is  
Dr. Fowler's report:

"The baby has been on digitalis and  
Hydrodiural since February 28th without  
any marked clinical improvement in the  
lung fields and, as stated, received  
Ampicin and gentamycin for a week.  
It is felt that the baby needs further  
investigation at the Hospital for Sick  
Children including cardiac catheteriza-  
tion."

Then at Page 3098 Dr. Rowe is discussing the autopsy  
after the baby died, which would have been in the  
record that you saw, and Mr. Lamek says at the  
bottom of the previous page:

"THE WITNESS: Well, first of all..."

Speaking of the autopsy:

"...it does confirm the clinical  
diagnosis or coarctation of the  
aorta."

That was Dr. Rowe, and then Mr. Lamek, like me,  
asked the next question:





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"Q. Yes.

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A. And bicuspid aorta valve and  
patent ductus arteriosus, And that  
the heart is enlarged.

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What we didn't have..."

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And I think here he is speaking of the pre-death  
observations:

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"What we didn't have, of course,  
evidence of clinically was the presence  
of fluid in the cavities, abdominal  
cavity, ascites, pleural effusions and inter-  
stitial edema and pulmonary congestion  
and edema, but those are really  
confirmatory of the conclusion that  
the heart failure was severe. The  
additional finding of amniotic..."

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How do I pronounce that, "squame"?

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A. Squame.

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Q. "...aspiration was not

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suspected, and the presence of sub-  
endocardial myocardial necrosis

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although predicted would not necessarily un-  
expected in a baby with a severe coarctation  
and heart failure because that is  
not uncommonly a finding at autopsy.

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2 But that is an important point because  
3 of the possibility that it may initiate  
4 arrhythmias.

5 The other point, of course, is  
6 that the baby was small for dates,  
7 meaning for the gestational age, of  
8 lower birth weight than expected.

9 Those are the main points."

10 Dr. Rowe goes on at Page 3099 to say at Line 12,  
11 speaking of the autopsy:

12 "...but I would have thought that there  
13 was sufficient findings there to  
14 account for death."

15 Now, what I want to ask you, Doctor, is I take it  
16 that you were not aware of that evidence until I  
17 read it to you?

18 A. That is correct.

19 Q. Does it have any impact on the  
20 severity rating that you affixed in the case of Kristin  
21 Inwood?

22 A. Perhaps I should amplify and  
23 say that I was not aware of the evidence, but I was  
24 aware of the findings. There is no question that  
25 the baby had a severe type of heart defect, but  
I do not believe that you can infer from the autopsy





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report as to the mechanism of the baby's death.

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We all agree that the baby was sick,  
but no, it does not change my original grading.

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Q. Well, the Commissioner is right  
that Dr. Rowe, in life, would have rated the baby as  
less severe, but his evidence is that the autopsy  
illustrates the severity of the condition to be more  
severe than he anticipated; would you agree with that?

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A. It appears as if this is the  
situation, yes, that he appears to be a little bit  
surprised when he described that the autopsy findings  
are -- he indicates the presence of severe heart  
failure. I am not sure that it is more severe than  
he expected. I am not sure I can arrive at this  
conclusion, but it was, nevertheless, severe.

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THE COMMISSIONER: Mr. Scott, I  
notice the title is "Prediction of Outcome Based on  
Condition Prior to Death." Is it based only on  
observations before death or is it not based upon  
what he discovered later?

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MR. SCOTT: No, you will remember, Mr.  
Commissioner, when Dr. Rowe was presenting that, you  
very fairly said to me, "Well, why doesn't he take  
into account everything?"

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THE COMMISSIONER: Yes.





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MR. SCOTT: The reason he did not, I think he gave to you, was that he was trying to duplicate insofar as he could the New England Academy analysis and that he, therefore, took into account only the symptoms that were revealed prior to autopsy.

MR. HUNT: I think Dr. Rowe did indicate that after looking at the autopsy reports he moved certain or would have moved certain of the babies from one of these categories to another, and it is not my recollection that Inwood was one of the ones that he would have moved, in any event.

MR. SCOTT: Well, I think your recollection on that score is wrong, Mr. Hunt, and I will dig up the point for you.

MR. HUNT: Thank you.

MR. SCOTT: But to answer the Commissioner's question, I think that this ---

THE COMMISSIONER: Well, I must say I had forgotten all of that, and the result is I have probably been putting too much faith in this document. If Dr. Rowe did deal with the document and transferred the babies in and out and round about, I would be grateful if you would point it out to me.

MR. SCOTT: Well, Dr. Rowe, in each

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case, gave his estimate of the cause of death.

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THE COMMISSIONER: Oh, I know.

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MR. SCOTT: But what he was trying to do here, you will recall, is match the kind of analysis that had been done in New England.

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THE COMMISSIONER: Yes, I understand it now.

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MR. SCOTT: Q. Now, in any event, Doctor, you would not make any change there?

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A. No.

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Q. Well, let us deal with the Baby Hines, which you have rated as a 3, and Dr. Nadas has -- Baby Hines is 02057, which is about five from the top. Do you see that?

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A. Yes.

16

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Q. He lists clinical status as intermediate, prognosis guarded, timing of death as expected and consistent with clinical symptoms.

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If anything, that is worse than the Baby Miller to whom you gave a 5 because the timing of death is expected.

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First of all, were you aware that Dr. Nadas had made this assessment of the Baby Hines?

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A. No, I was not.







(Scott)

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Q. Does his opinion have any significance as far as you are concerned in evaluating the severity of this case, or do you simply put it aside?

A. No, I would not put it aside. I have a great deal of respect for Dr. Nadas.

I do not quite understand what his reasoning is for placing the baby in this category, and I am perhaps a little surprised. There is a description which I believe is provided by him on Page 58 about this baby, and perhaps if I could just read that.

Q. I am not sure that that is a description by him, but you can certainly look at it. You are looking under the number 02057, are you?

A. That is correct.

Q. Yes.

A. No, I see that the report is not by him since they mention him later in the last sentence here and indicate his rating of the case.

Q. Well, just to finish this up, it is apparent, is it not, that there is a difference of opinion of some dimension between you and Dr. Nadas in characterizing the severity of this case?





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A. Yes, there is.

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MR. SCOTT: If I could just finish up  
this baby, Mr. Commissioner. I do not know when you  
want to take your break this morning.

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THE COMMISSIONER: Well, whenever it  
suits you.

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MR. SCOTT: Q. At Volume 17, Page 2856,  
in discussing this patient, Dr. Rowe is asked at  
Line 10 -- do you want me to show you this?

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A. I do not have Volume 17 here.

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Q. Let me show you this. Dr.  
Rowe is asked about the Sudden Infant Death Syndrome,  
and he says:

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"Q. The near miss Sudden Infant  
Death Syndrome. Is Sudden Infant Death  
Syndrome something that may recur  
if interrupted once, twice?

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A. Yes. Yes, indeed, there is a  
high risk of that happening."

19

First of all, were you aware that Dr. Rowe had given  
that opinion?

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A. No, except when I read his  
report just Friday, a few days ago.

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Q. Having heard that opinion, do  
you agree with it?

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BmB.jc

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A. Yes, I agree with what he said  
about the missed-Sudden Infant Death Syndrome.

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Q. So, I take it if this was a  
case where there had been a missed-Sudden Infant  
Death Syndrome there would be a high risk of its  
recurrence, as Dr. Rowe says?

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A. Yes, I agree with that.

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Q. Yes. And I take it that if  
you put that fact, assuming that to be the case, if  
you put that into the mix you are led to give a  
higher severity rating for the Baby Hines, are you  
not, than 3?

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A. Yes. I think Baby Hines is  
a very difficult one to analyze and I think several  
diagnoses have been brought forth here as to the  
possible explanation for his death which includes  
digoxin overdose, a missed-Sudden Infant Death  
Syndrome, sepsis, and the sick sinus syndrome, to  
explain the arrhythmias.

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Now, I have just recently again  
reviewed his chart very carefully and it is a  
difficult case, I am the first one to concede this.  
However, if you take each of the symptoms that we  
are just talking about here, for instance, bradycardia,  
tachycardia, and try to explain this on the basis

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F.2

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2 of one or the other, it is not that easy. This is  
3 why I chose the diagnosis of sick sinus syndrome  
4 although, it would be a very rare situation where a  
5 baby would die of sick sinus syndrome. I could very  
6 well be wrong here and perhaps sepsis may be a  
7 better diagnosis, perhaps even a missed-Sudden Death  
8 situation. If you could exclude everything else  
9 that is my opinion though that you would have to  
10 exclude, and if you accept the hypothesis of SIDS  
11 here, you still have problems trying to explain the  
12 bradycardia/tachycardia, especially the tachycardia,  
13 explain the terminal episode where, from the nurse's  
14 description, it appeared as though the bradycardia  
15 preceded the apnea rather than the other way around  
16 which would be what you would expect with Sudden  
17 Infant Death Syndrome where the apnea would come  
18 first and then the bradycardia.

17 You would have difficulty of course  
18 explaining the high concentrations of digoxin in  
19 the baby's tissues.

20 Q Well, leaving aside the  
21 digoxin altogether for a moment, I take it that a  
22 evaluation or the diagnosis of this baby presents a  
23 difficult problem no matter which of the alternatives,  
24 SIDS or sepsis or triple S you settle on?  
25





F.3

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A. Yes.

3

Q. Yes. And I take it that

4

because you have settled on triple S, that naturally

5

leads you to a less severe rating in this case than

6

you would give it if you settled on missed-SIDS?

7

A. You see, my problem is that --

8

Q. First of all, could I ask you,

am I right about that?

9

A. Could you repeat it, please?

10

Q. Yes, I'm sorry. You have

11

settled on sick sinus?

12

A. Yes.

13

Q. This is getting too simple as

14

the diagnosis here, and you have commented that

that doesn't usually lead to death?

15

A. True.

16

Q. And that would therefore lead

17

you to give a less severe cardiac rating to this

18

patient?

19

A. Yes.

20

Q. Yes. I take it that if another

21

doctor or if you had settled on missed-SIDS as a

diagnosis, you would be inclined to give a higher

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rating of risk than you have given?

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A. Yes.

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Q For the reason that Dr. Rowe gave that there is a high risk of a repetition?

A Yes.

Q Yes. So that I suggest to you that if in the end it is concluded that this is a SIDS or missed-SIDS case, your allocation of a 2 would be elevated to, say, 6 or 7?

THE COMMISSIONER: Is it a 2?

MR. TOBIAS: It was a 3, sir.

MR. SCOTT: 3, I'm sorry.

THE WITNESS: Yes, it would be elevated.

MR. SCOTT: All right.

Now, perhaps we should take the break, Mr. Commissioner.

THE COMMISSIONER: Yes, all right. We will take I think 20 minutes.

--- Short recess

--- On resuming:

THE COMMISSIONER: Yes, Mr. Scott?

MR. SCOTT: Just to clarify a point raised by Mr. Hunt before the break. On Exhibit 127 regarding moving babies after examining the autopsy on Monteith and Taylor. That is at page 3517 of the transcript.

THE COMMISSIONER: Monteith and Taylor





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were transferred from where to where?

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MR. SCOTT: Well, they were transferred  
in Volume 20, page 3517.

4

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THE COMMISSIONER: Monteith and Taylor  
were transferred to, what, lower risk or to inevitable  
death?

6

7

MR. SCOTT: To higher risk - to high  
risk death list.

8

9

THE COMMISSIONER: They are in there,  
now?

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11

MR. SCOTT: Yes, after autopsy.

12

THE COMMISSIONER: I'm sorry?

13

MR. SCOTT: If you look at his sheet.

14

THE COMMISSIONER: Yes, I have it here  
and it is in high risk, but do you mean that is ---

15

MR. SCOTT: I want to get this over  
before Mr. Hunt turns up.

16

17

THE COMMISSIONER: Well, at the moment  
they are right now in the exhibit they are in under  
high risk death.

19

20

MR. SCOTT: It is Exhibit 127.

21

THE COMMISSIONER: Yes, I have it, I  
have it here. But where did he transfer them from  
and to what?

22

23

MR. SCOTT: He transferred them from

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F.6

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lower risk death, as I understand it.

3

THE COMMISSIONER: To high risk death?

4

MR. SCOTT: To high risk death.

5

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THE COMMISSIONER: You see, that was my problem, because I thought that this was the final result that he gave, and I think it is, is it not, the final result?

8

9

MR. SCOTT: Well, it looks as if you are right, sir.

10

THE COMMISSIONER: Yes.

11

12

MR. SCOTT: That is the way I understood it.

13

14

15

Q. Now, Doctor, dealing with Baby Hines again. I take it from your report, which is at page 8 of your book, the difficulty that you had with the -- do you have that?

16

A. Yes.

17

18

Q. Down in the second last paragraph you say:

19

"At autopsy -- ",  
are you with me there?

20

21

A. Yes.

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23

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Q. "At autopsy there were findings suggestive of a missed-SIDS or such as persistent extramedullary





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"erythropoyesis, brown fat and thickening of the pulmonary artery. However, SIDS does not explain the arrhythmia."

I take it it was the presence of the arrhythmia that in significant measure persuaded you to go with triple S rather than with SIDS?

A. Yes.

Q. Yes. And that was because in your view arrhythmias could not be explained by SIDS?

A. This type of arrhythmia.

Q. Now, I want to show you what Dr. Rowe says about it, speaking of the Baby Hines at Volume 17, 2856. It is a very short passage and I will just show you mine so we won't waste any time. He is speaking about Hines and Sudden Infant Death and it follows on the passage I read earlier:

"Q. Are cardiac arrhythmias known to be associated with Sudden Infant Death Syndrom?

"A. They are with some.

"Q. With some?

"A. Yes.

"Q. Is that a common ...

"A. I do not know how common that is,





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"but it does occur. It can occur,  
let us put it that way."

Do you agree with Dr. Rowe on that  
subject?

A. I'm not really --

Q. I'm not saying that all doctors  
have to agree on everything but I am simply asking  
if you agree with him on that subject?

A. Well, as I said earlier, I am  
no expert in Sudden Infant Death Syndrome. I am not  
sure whether they are referring here to the terminal  
events because arrhythmias can certainly occur very  
terminally and that wouldn't surprise me, or whether  
they are talking about arrhythmias which occur  
earlier, and I am really not perhaps qualified to  
speak on that.

Q. Well, just to have it, I take  
it that you wouldn't quarrel with Dr. Rowe's  
conclusion?

A. My concept of Sudden Infant  
Death Syndrome and - well, I know a little about it -  
is that it is a diagnosis of exclusion. It used to  
be more so perhaps than it is now. Now there has  
been a great deal of emphasis placed on the apnea  
and chronic hypoxia that these babies are exposed to







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and it perhaps has become a more specific diagnosis, also, the autopsy findings which corroborate the chronic hypoxia. However, I still find it very difficult sometimes to pinpoint it. This diagnosis, when you have other problems that could possibly explain the baby's death, such as, sepsis or sick sinus syndrome, in this particular situation.

Q. Yes. Well, I understand that you don't put yourself forward as an expert in SIDS but what I am suggesting to you is that arrhythmia, the presence of these arrhythmias was the principal reason that led you to exclude SIDS?

A. That is correct.

Q. Yes. Now, what I'm suggesting to you is that if Dr. Rowe is right about arrhythmias and SIDS, you may want to, on reflection, reconsider your diagnosis?

A. Well, I would really have to study his references and what he is referring to more accurately or in greater depth before I would change anything.

Q. Well, let me see if I can give you something else. Dr. deSa's report, which we just have this morning, deals with this question at page 13, and as we only seem to have one copy I will





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read it with you. He is dealing I tell you on  
page 13 with Baby Hines, and of course he is a  
pathologist.

5

A. Right.

6

Q. If I can stop you. Have you  
read Dr. Becker's evidence about the baby Hines?

7

A. Yes, I read some of it.

8

9

Q. Yes. Well, here is what  
Dr. DeSa says:

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"I agree with the conclusion that  
these changes ... "

11

12

and he is referring to the changes noted at autopsy:

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" ... are compatible with those of  
Sudden Infant Death Syndrome. My  
review also showed evidence of small  
myocardial petechia hemorrhages and  
while no definite evidence of  
myocardial necrosis could be seen,  
it was obvious that this infant had  
suffered an acute cardiovascular  
collapse. This infant did not show  
any evidence of any significant  
infection which might have precipitated  
its sudden demise. No significant  
congenital malformations were seen.





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"By definition the Sudden Infant Death Syndrome is not associated with any specific morphological abnormalities and the only changes that are present, such as those seen in this infant, are of a relatively subtle nature and compatible with episodes of chronic hypoxia. It is known that episodes of apnea and bradycardia may precede cardiovascular collapse in the Sudden Infant Death Syndrome and the concept of near missed situations and the Sudden Infant Death Syndrome is well recognized.

"By its very nature, however, the Sudden Infant Death Syndrome is one of the anomalous situations where an acute death may be associated with no significant anatomical cause. It is in this regard and this regard alone that I include this case as one of those three where there is poor correlation between the morphological findings and the clinical picture.





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"This is not a reflection on the completeness of the examination by the pathologist but reflects the nature of the syndrome."

Now, I take it you would not quarrel with that, would you?

A. No, sir, I wouldn't.

Q. All right.

A. I just wonder what he says further?

Q. Well, I think he deals with another case further.

A. All right.

Q. Anything else he says on the baby Hines he says on pages 11 and 12.

A. All right.

Q. Do you want to look at that?

A. Maybe I can just take a quick look.

I think we are dealing here again with probabilities and if you look at all the experts' evidence here I think this evidence indicates that the diagnosis of Sudden Infant Death Syndrome or sepsis or other diagnoses are the most likely one. I don't think anybody can really arrive at a final







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complete decision here as to a diagnosis.

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Q.

Well, having heard the evidence of Dr. Rowe, having read something about what Dr. Becker said and having read what Dr. deSa says, does any of that lead you to some anxiety to review with an expert on SIDS if necessary your conclusion that this was not SIDS?

A.

Well, I would certainly be open to review this situation again and preferably with experts in this particular area. So far I am not totally convinced at all that this is SIDS. I would perhaps raise my probability level with regard to SIDS to a higher degree. I think I would do that, but as I mentioned earlier I don't think that would explain everything.

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Q. Well you have approached the question of SIDS I take it on the basis that perhaps it is the traditional view that it is a syndrome which is a syndrome of exclusion, have I got it right?

A. I think that is a very important factor.

Q. Well, I want to show you a report from the American Heart Association dated November 29th, 1983, which suggests from its title that SIDS is linked to cardiac and not respiratory problems. Before you read that, I want to ask if you are familiar with the - any of the research that this article attempts to summarize?

A. Yes, I am somewhat familiar. I know the investigators, I know Dr. Bharati very well because I worked with her for a while.

Q. Dr. Bharati I take it is highly respected in this field?

A. Yes.

Q. And you would have great confidence in her level of accomplishment?

A. Yes.

Q. Now it is a summary and not in her words, but the second paragraph says:

"The syndrome may result from faults





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"in the conduction system of the  
infant heart, which can trigger fatal  
ventricular arrhythmias."

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Now assuming for the moment that that  
is so, it is just a summary and we don't know that  
it is so, but assuming that it is so, I take it  
that that would lead you to re-evaluate your assess-  
ment of the Baby Hines case?

9

A. No.

10

Q. Why not?

11

A. Because I am familiar with this

12

study. There have been perhaps 25 hypotheses as

13

to the cause of SIDS and this is only one of them.

14

Q. All right.

15

A. And I think it is a good one,

16

but there is a big gap between the pathological  
findings that you can see and the explanation of

17

the clinical course of these babies, this is by no

18

means clear. To say for instance that - the second

19

little paragraph says:

20

"The syndrome may result from faults

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in the conduction system of the infant

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heart, which can trigger fatal

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ventricular arrhythmias."

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The faults of the conduction system

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are there, no question about it, but then he goes on to say:

"...which can trigger fatal ventricular arrhythmias."

Now, we don't know that, we can't say that from looking at the conduction system. There is a correlation between clinical findings and conduction system abnormalities.

If you have a group of let's say children who died with SIDS and they all had the same problem and so forth, then you could really establish a good correlation perhaps, you know.

Q. Have I got it right that the effect of Dr. Bharati's work is to establish a correlation between arrhythmias and the conduction system?

A. Yes.

Q. And that assuming her conclusions to be correct, which we must in every case, then you would have SIDS with arrhythmias?

A. I am not so sure that that is correct. Because my understanding would be that you would have a situation which would make the infant more susceptible to an arrhythmia and then this arrhythmia may be the sudden terminal event,







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3 and possibly, very often, not detected at all.

4 The problem with this study I think  
5 is to really verify or prove that these babies had a  
6 specific type of arrhythmia and that this specific  
7 type of arrhythmia can be correlated with the patho-  
8 logic lesions, I think this is the missing link here.

9 Q. Well, if you will turn to the  
10 fourth column of that article.

11 A. Yes.

12 Q. Dr. Bharati is quoted, the  
13 third paragraph down, Dr. Hastreiter.

14 A. Yes.

15 Q. "Various abnormalities informa-  
16 tion of the conduction system, which  
17 in the past have been considered normal  
18 variations may, in certain persons,  
19 especially infants, be responsible  
20 for irregular heart rhythms that lead  
21 to sudden death."

22 Now, Dr. Bharati is no wild eyed  
23 radical on the fringe of science, is she?

24 A. No, but she says herself "it  
25 may".

Q. All right. All I am getting  
at is to ask you, Doctor, is this, that you rejected





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SIDS in part because of the presence of arrhythmias,  
right?

A. Yes.

Q. And what I am getting - I hope  
I can get you to say is that increasingly current  
work shows that arrhythmias may be a characteristic  
of SIDS, not a reason for excluding it, but rather  
a reason for including it.

A. I haven't seen this work.  
This, what you have shown me here is not proved to  
this hypothesis. I would have to see clinical work  
showing that babies who are labelled "SIDS" definitely  
had arrhythmias preceding death, and this I think is  
what is missing. There may very well be reports  
and I just have no knowledge of them.

Q. All right. Can we mark that  
as an exhibit, Mr. Commissioner?

THE COMMISSIONER: Yes.

MR. TOBIAS: Excuse me, in fairness,  
if my friend is putting the article to the Doctor  
perhaps he could put the last five paragraphs of  
the article to the Doctor.

MR. SCOTT: That is what cross-  
examination is for, that is what cross-examination  
is for. I only have a certain amount of time and I





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am not going to waste it by saving Mr. Tobias time.

THE COMMISSIONER: 284.

---EXHIBIT NO. 284: SIDS may be linked to cardiac  
- not respiratory - problems,  
Dr. Saroja Bharati, the  
Medical Post, November 29th,  
1983.

MR. HUNT: If I my friend is going  
to put any other articles to the Doctor I suggest  
it is not a waste of time to let the Doctor read  
the whole article.

MS. SCOTT: No, no ---

MR. HUNT: You have already starting  
picking paragraphs out of context.

THE COMMISSIONER: Did I understand  
that you had already seen this article?

THE WITNESS: I hadn't seen this  
particular article, but I was familiar with the  
work.

THE COMMISSIONER: With the work,  
I see. Well, I think we will leave it as Mr. Scott  
suggests for his successors to deal with it, and you  
will get another turn too.

MR. HUNT: If he is going to put  
any more, if he is going to put in a page of a  
newspaper, he should not pick paragraphs out here











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3 and there.

4 THE COMMISSIONER: You will forgive  
5 him for his past indiscretions, you just want him to  
6 behave in the future.

7 MR. HUNT: Yes.

8 THE COMMISSIONER: Yes, yes, all  
9 right.

10 MR. SCOTT: It makes me very nervous  
11 to be so closely watched as I am by Mr. Hunt.

12 THE WITNESS: If I may refer to  
13 this paragraph, the fourth paragraph from the end.

14 MR. SCOTT: Q. Now you are down  
15 to what Mr. Tobias wanted you to do.

16 A. That is right, exactly.

17 "Although we need ECG patterns from  
18 ante mortem findings before we could  
19 say that these abnormalities had set  
20 up any irregular rhythms of the heart,  
21 (et cetera, et cetera) anatomically  
22 these hearts do vary from the normal  
23 and possibly could have produced  
24 lethal arrhythmias,"

25 Q. Doctor, I haven't made myself  
clear. We have had two experts on SIDS give  
evidence about these cases, and I am not asking you





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3 to be an expert. I am simply asking you in view of  
4 the fact that you excluded SIDS because of the presence  
5 of arrhythmias, with the work being done in which  
6 the arrhythmias are indicative of SIDS, does that  
7 lead you in fairness to qualify the exclusion you  
8 have made?

9 A. Well, the work that you showed  
10 me here does not convince me.

11 Q. All right. Well, I will  
12 consider that whole exchange for these purposes a  
13 net loss.

14 Now let's come to some other cases.  
15 You and Mr. Lamek, Mr. Lamek went through with  
16 you some cases in which you said I think that there  
17 was a "good probability", have I got the words right,  
18 you dealt with some babies in which there were no  
19 toxicological data whatever, and you analyzed the  
20 cases and you were asked I think to ---

21 MR. HUNT: Could we just have the  
22 page reference, Mr. Commissioner, to save some time?

23 THE COMMISSIONER: What is that?

24 MR. HUNT: Could we just have the  
25 page references, Mr. Commissioner, I think my friend  
is about to put some evidence to the witness given  
to Mr. Lamek.





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MR. TOBIAS: Mr. Commissioner, before my friend moves on, is this article going to be made an exhibit?

THE COMMISSIONER: Yes, it already is, it is Exhibit 284.

MR. TOBIAS: Thank you, Mr. Commissioner.

MR. SCOTT: Q. You dealt with some seven or eight babies in which there was no toxicological data.

THE COMMISSIONER: Just a moment.

MR. OLAH: I hate to intrude on this but in some cases there was, Onofre is one example, and in some cases my friend is right.

MR. SCOTT: Is right about what?

MR. OLAH: About there being no digoxin data being available, in some instances there was digoxin data and in some instances there wasn't.

THE WITNESS: Perhaps we should deal specifically with each case, I don't know.

MR. SCOTT: Q. Yes. I want to - at page 6810 in Volume 77 you made what you called a compilation, or Mr. Lamek made a compilation ---

THE COMMISSIONER: I don't seem to have it.

THE WITNESS: What page? Thank you.





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MR. SCOTT: I don't think you will  
need it, Mr. Commissioner.

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THE COMMISSIONER: All right.

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MR. SCOTT: Q. Perhaps we can  
begin with page 6809 so Mr. Olah won't be unhappy;  
at line 14:

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"Q. I want to look now, Dr. Hastreiter,  
at a few additional children of whom  
it was your opinion, based on a review  
of their clinical records, that there  
was a good or fair probability of  
massive digoxin overdose, and first  
the good probability group."

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Then he lists them:

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"Babies Taylor, Shrum, Gage, Onofre,  
MacDonald, Gosselin and Woodcock.

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THE COMMISSIONER: These are found -  
where are they - this is your own  
compilation I take it?

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MR. LAMEK: My own compilation, yes.

20

21

THE COMMISSIONER: Could you give  
it to me again?

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MR. LAMEK: Taylor, Shrum, Gage,  
Onofre, MacDonald, Gosselin and  
Woodcock.

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"Q. And of those seven there are toxicological data about only three and that as we will see a rather devious value, Gage, Onofre and Woodcock."

Now, you know the babies we are talking about?

A. Yes.

Q. And I take it that you, as you said, were led to rate them as "small", "fair" or "good" in terms of a massive digoxin overdose; and the definitions are "small", "fair" and "good" are contained on the second page of Exhibit 261 which are the minutes of the meeting of September 13th.

A. Yes.

Q. And the seven babies whose names I have just read were those that you characterized as "good" from the point of a massive digoxin overdose?

A. Yes.

Q. And you have also told us that you were performing a sieve-like function in which you exclude only those babies whose death could with very complete assurance be ascribed to natural causes?





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A. That is true.

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Q. And the "good" characterization  
meant no more than that the cases listed justified  
some further investigation?

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A. That was the main purpose.

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Q. Yes, and that is the main  
conclusion we are to draw from the fact that those  
babies are found in that category of yours, that the  
cases merit further investigation?

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A. Yes.

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O. If we can take the Baby Woodcock

first, I want to show you what Dr. Rowe had to say  
about this baby at Volume 18, and I will get it  
for you, Page 3055. We will bring up a copy,  
Doctor.

A. I think I have it here.

Q. And I summarize by saying  
that Dr. Rowe's evidence was that the cause of  
death of this baby at the moment of death was un-  
certain, and that is why the coroner was notified.  
But Dr. Rowe's evidence, which I will read in a  
moment, was that the autopsy was extremely helpful  
in characterizing the baby's death. What he says  
at Page 3055 at Line 10:

"O. But at Page 33..."

And he is referring to the record:

"...it is recorded:

'At necropsy, the lungs appeared  
moderately congested and microscopic  
examination revealed an extensive  
pneumonia with foamy macrophages...'

A. Yes. But it was a cause of  
some puzzlement for the clinicians  
at that time as to exactly what that was  
going on there, because the baby had not





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been greatly distressed by rapid  
breathing or anything like that as  
far as I can recall.

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So that, I think, is important  
in view of those autopsy findings. Then  
the last episode is -- I am sure you  
want to go into that.

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Q. Yes.

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A. And I think that the autopsy  
showed that there was not any definite  
congenital anomaly of the liver but  
a condition called cholestasis which  
is just severe congestion in the liver.  
I think the liver people, if you want  
to know more about that, you will have  
to ask them because I am certainly not  
qualified to talk about that a lot, but  
it is the sort of thing that is some-  
times only discovered at autopsy as  
to the precise reason for the liver  
problem.

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"During life, there is always  
a lot of concern about whether it is  
viral hepatitis or whether it is  
obstructive congenital jaundice."







1  
2 Then he deals with the mildness of  
3 the congenital anomalies of the heart, a conclusion  
4 with which I think you have already agreed, and  
5 then at Line 21:

6 "Q. The pathologist suggested  
7 that that was one of the things that  
8 had occurred in the course of the  
9 terminal events, did he not?"

10 That was the blister on the microvalve.

11 "A. Maybe, yes. So that the main  
12 findings in the autopsy were the  
13 pneumonia, which I thought was the  
14 significant contribution, the fact  
15 that there had been some previous  
16 hypoxia and that there was an infarct  
17 of the papillary muscle which might  
18 conceivably have attributed to the  
19 arrhythmia, but certainly the con-  
20 genital heart disease itself was not  
21 sufficient to account for death.

22 Q. Indeed, Doctor, on the question  
23 of the infarct of the papillary muscle, on  
24 Page 33 of the chart, I am not sure that  
25 I see any reference to that there, do I?

A. Well, about four lines on Page





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How do you pronounce that?

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33 from the top, '...a small old sub-endocardial left ventricular myocardial infarction.'

Q. Oh, yes, I have it, thank you.

A. It is not large enough to cause damage to the function of the heart as far as the pump is concerned, but it might be a factor in initiating a rhythm disturbance.

Q. So as far as the pathologist was concerned, towards the end of his report, the second last sentence, he says:

'The exact cause of the sudden, cardio-respiratory arrest is uncertain.' And **this** in his final autopsy report, in the light of the findings he has made on autopsy. Did you share that view, having seen the final autopsy report?

A. Well, I would have thought the pneumonia was enough to account in a child who had a major hyperbilirubinemia..."

A. Hyperbilirubinemia.

Q. It is obviously a Welsh disease.





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A. Hyperbilirubinemia.

3

Q. "...account for the arrest, and  
perhaps in conjunction with dysrhythmia  
from the scar."

4

5

Now, what Dr. Rowe, if I have it right, is saying is  
that the congenital features of the heart do not  
explain this death but that the pneumonia and  
dysrhythmia perhaps from the scar is enough to  
explain it.

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Then at Page 5152 in Volume 28 --

11

we will get that -- at the bottom of Page 5152,

12

Dr. Freedom says:

13

"Q. Sitting here today, Dr. Freedom,  
do you have an opinion as to the  
probable cause of death of this  
child in light of those postmortem  
findings?

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A. You know, at post mortem the  
youngster had fluid in chest  
cavities, in the abdomen, and I

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would wonder whether this process was  
a toxic process of the bilirubin  
directed towards the central nervous  
system.

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Q. And do you find support for that

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concern, Doctor, in anything contained  
in either of the preliminary or final  
autopsy report

A. Yes First of all they talk on  
number 1 and 2 the patient had  
extensive bilateral pneumonia."

Then he goes back to the final report at the bottom:

"A. Again, if it described giant  
cell formation, Ms.Cronk, that is  
not just based on preliminary informa-  
tion, that is using a microscope. So,  
this youngster had extensive pneumonia  
bilateral with congestion and edema;  
that's number 1. Number two, he had  
a severe..."

You are going to have to help me here.

A. Cholestasis.

Q. Thank you.

"...and that means plugging of the  
liver with bilirubin. There was con-  
gestion of the organs, as listed in  
number seven. So, again, this was  
obviously an ill youngster but it  
was apparent that the heart disease  
holds relatively little risk to this







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baby in isolation."

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Now, both Dr. Rowe and Dr. Freedom gave those causes

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as the cause of this baby's death, one based on

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clinical observation and autopsy and one based on

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the record including the autopsys, and I want to ask

7

you if their opinion is an acceptable opinion?

8

A. Well, with all due respect to  
both of them, I do not think so. I ---

9

Q. What is your opinion as to the  
cause of death?

10

11

A. Well, first of all, maybe I  
should point out that although both Doctors Rowe and  
Freedom have tried to explain the death on the basis  
of these findings, they have different reasons, like  
Dr. Rowe indicates that the lung problem, the  
pneumonia and possibly the necrosis, the small area  
of necrosis of the myocardium may be responsible.

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Dr. Freedom, on the other hand, although he also speaks  
about the pneumonia, his main concern appeared  
to be the high bilirubin producing brain damage which  
is a well known situation. But I do not think there  
was any indication of this occurring in this  
particular baby.

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22

Now, if I may counter these hypotheses---

23

Q. Before we get to that, may I ask

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you to do something else?

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A. Yes.

4

Q. Could you tell me the complaints  
you have about Dr. Rowe's assessment?

5

6

A. Well, what Dr. Rowe is doing is  
he is taking pathological findings and is trying  
to fit the terminal event into these findings.

7

8

In other words, he is developing a hypothesis which  
he is trying to fit into the pathological findings.

9

10

I think the hypothesis is good, but there  
could be many other hypotheses that could fit these  
findings, and they remain very hypothetical because  
there is no proof whatsoever that the little area  
of necrosis in the myocardium did indeed produce an  
arrhythmia. I mean, this is a possibility.

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Q. Let me ask you this, Doctor:  
is there any part of the record that you think  
Dr. Rowe has overlooked in approaching this  
hypothesis or is there any part of the record  
which is inconsistent with the hypothesis, and  
if so, would you be good enough to tell me what  
it is?

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A. I do not feel that Dr. Rowe  
overlooked anything. I also am not saying that the  
facts are inconsistent with his hypothesis, but they





1  
2 are also -- all I am saying is that the facts are  
3 really not enough to explain this child's death; at  
4 least there is no obvious explanation for this  
5 child's death and that Dr. Rowe and Dr. Freedom  
6 are both trying to fit the clinical course, as  
7 well as they can, into these pathologic findings.

8 I think it is a weak case, in my  
9 opinion, because it is all circumstantial. It is  
10 all, you know, like you would say in a trial,  
11 circumstantial evidence, I think.

12 Q. Let me ask you this: if the  
13 Baby Woodcock had died in your hospital, what would  
14 you have assigned as the cause of death?

15 A. I would have been very puzzled,  
16 first of all, because there is no obvious cause of  
17 death. In fact, from what you just showed me, I am  
18 perhaps even more convinced now that the liver  
19 disease was not as bad as I originally thought it  
20 might have been, and I do not find a good cause  
21 of death here to explain this baby's ---

22 Q. Well, let me ask you again  
23 because we want to have it clear, there will be other  
24 people giving evidence on this subject, what is it  
25 in Dr. Rowe's opinion that you quarrel with?

A. Well, the fact of the link





(Scott)

1  
2 between the pathology. There are some obvious  
3 pathological findings. We could relate to three  
4 findings. One would be the liver disease, one would  
5 be the pneumonia, and the third one would be  
6 the little area of necrosis of the myocardium.

7 Doctors Rowe and Freedom are trying to  
8 relate this child's death to these three pathological  
9 findings. Now, in my opinion, the liver problem can  
10 pretty well be excluded because it does not produce  
11 sudden death. If it had produced brain damage which  
12 in turn resulted in sudden death, like Dr. Freedom  
13 indicates here, the possibility, this would have  
14 been detected at autopsy. They should have shown that  
15 the brain had certain specific lesions that would  
16 account for the problem, and this was not done.

17 Now, the second item, the little  
18 area of necrosis in myocardium as possibly producing  
19 an arrhythmia, that is always a possibility, but to  
20 link this with the arrhythmia, the link is very weak.  
21 In other words, there are many children who die  
22 who have force of necrosis in the myocardium, and  
23 very few of those children die because of it. They  
24 usually die of something else.

25 Q. Well, Doctor, perhaps I can  
put my concern ---







1  
2 MR. HUNT: Could the doctor just finish,  
3 please, because he has still got one more to go  
4 through.

5 THE WITNESS: Yes, I have the pneumonia.  
6 That, to me, is the most important one. But the  
7 problem with this pneumonia, although it was  
8 extensive, it was rather marked, the problem is  
9 the timing, because this pneumonia was apparently  
10 acquired at the time of the birth. This baby was  
11 already two weeks old, I believe, two and a half,  
12 almost three weeks old at the time of death, and  
13 there was no indication that the child had any  
14 respiratory distress or any deterioration with re-  
15 gard to the lungs, the pulmonary function. In fact,  
16 Dr. Rowe himself states here that he was surprised  
17 because the child showed no indications of  
18 respiratory distress. Therefore, not only that, but I  
19 think in the pathology report, although I do not have  
20 it here with me, the pathologist indicated there was  
21 extensive pneumonia with foamy macrophages at  
22 autopsy, but this was felt to be related to the  
23 perinatal difficulties, that is, at the time of  
24 birth. Therefore, the timing is wrong for this  
25 pneumonia to kill this child at that particular  
time. It should have killed the child shortly after





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birth if it were to do it.

Q. Doctor, we know that the doctors at the Hospital for Sick Children were uncertain about the cause of this death because they notified the coroner, which is what you do in Ontario if you are uncertain about a death.

A. Right.

Q. And what I want to say to you ---

A. Chicago also.

Q. In Chicago also. If this baby had died in your hospital, you would have notified the coroner or whoever you have in Chicago; do we agree with that so far? Would you have notified the coroner in a case like this?

A. Yes.

Q. All right. Now, at your conference the following day, what hypothesis for the death would you have suggested as worthy of serious consideration by your staff?





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A. you mean knowing the autopsy reports?

Q. I presume Chicago and Toronto are the same, you just don't say the baby died and that case is over, we go on to another one, you make some analysis and try to posit an hypothesis, don't you?

A. Well, the very reason we called the coroner in is because we don't know what the baby's death was.

Q. Yes.

A. But we have to hypothesize.

Q. Dr. Hastreiter, if you don't have to hypothesize surely the coroner does, doesn't he?

A. The coroner, his function is to try and find a reason.

Q. Yes.

A. A cause or at least the most likely reason. If he does not find one, you know, his diagnosis is not very conclusive I don't believe.

Q. All right. Well, what hypothesis would you suggest for serious consideration if this baby had died in your hospital?

A. I'm really at a loss to explain this child's death on the basis of these findings.





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Q. Have you any hypothesis to suggest as to why this child died?

A. I think the best you can do ---

Q. If this child dies in your hospital?

A. ... if you exclude digitalis ---

MR. LAMEK: Will my friend please allow the doctor to finish an answer occasionally.

MR. SCOTT: Q. All right.

A. Thank you. If you exclude the hypothesis of a digitalis overdose here and you are trying to explain this child's death on the basis of the other findings here, I think the best explanation would probably be that we have a combination of factors here: liver disease, pulmonary disease and possibly some heart disease. There was a mild type of heart disease in addition, and that this combination of factors, perhaps you could invoke that as your explanation, but it is still in my opinion not a very strong case.

Q. Well, would you agree then that the hypothesis you would suggest if this baby died in your hospital was precisely the hypothesis that Dr. Rowe and Dr. Freedom suggested; a combination of items including pneumonia, the liver disease, the







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mild heart condition?

A. Yes, that was what they suggested. I don't know how strongly they were convinced that this was the reason but that was what they suggested.

Q. And just so I have it that if the death had occurred in your hospital it is the same kind of hypothesis that you would go with?

A. Yes.

Q. Yes. Now, were you aware from Exhibit 150 that the coroner had looked at this baby and found that death was based on natural causes?

A. No, I don't know what the coroner's report stated. I would perhaps like to look at it if I could.

THE COMMISSIONER: If yours is like mine, Doctor, it is the second last page.

THE WITNESS: No, this is only one page I believe, is it not?

THE COMMISSIONER: One page for each, I think.

THE WITNESS: For each, yes.

THE COMMISSIONER: And the second last page, if you turn right over I think you will find the child's name is in the blocks over to the





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top right-hand corner.

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THE WITNESS: Yes.

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THE COMMISSIONER: You will find

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Woodcock there.

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THE WITNESS: Yes.

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MR. SCOTT: I think it is the front one  
on ours.

8

THE COMMISSIONER: Oh, yes, I beg

9

your pardon, all right. Well then, you have a

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different copy from mine.

11

THE WITNESS: Yes.

12

MR. SCOTT: Q. And what does the

13

coroner conclude about the cause of death in the case  
of Baby Woodcock?

14

A. Excuse me just a second. Well,

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I find it interesting that the coroner says the

16

infant was found to have pulmonary stenosis. I don't

17

see any evidence of pulmonary stenosis from the other

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report now, I don't know. My diagnosis here was that

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of ventricular septal defect:

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" ... and had a sudden cardiac arrest

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at 9:03 hours on the 30th of June,

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1980 and could not be resuscitated.

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The hospital obtained permission for

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an unofficial autopsy. Upon my

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"investigation I was satisfied that death was due to natural causes and determined that no official autopsy or inquest was necessary."

Well, that's interesting, but it doesn't convince me.

Q. No, I'm not asking that you should be convinced. What I'm trying to highlight, and perhaps it is obvious by now, that there is a substantial and legitimate difference of opinion about the interplay of these factors whether the death had occurred in your own hospital, which is neutral ground for these proceedings, or as it did in June at The Hospital for Sick Children? That's fair, isn't it?

A. Isn't there a description of the coroner's findings because this opinion must be based on some findings of which I am not aware of.

Q. Maybe Mr. Hunt can provide that. The coroner, like you - I shouldn't say like you - the coroner is his client but what I am simply getting at is that the hypothesis that was advanced by the doctors at The Hospital for Sick Children in June or July of this year is substantially the hypothesis that you would have advanced as you have





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already told us if the death had occurred in Chicago;  
right?

A. Yes.

Q. And the hypothesis - I mean,  
I'm sure the coroners in Ontario are by and large  
excellent and I don't know anything about this coroner,  
but the hypothesis appears to be accepted as far as  
one can judge by the coroner's determination that it  
was natural causes?

A. I still find it a weak case.

Q. Well, what I'm suggesting to  
you, if you look at the minutes of this meeting on  
September 13th, and I am looking at the vote.

A. Oh, okay.

Q. Dr. Fay, an eminent expert,  
isn't he?

Dr. Bennett and Dr. Tepperman who  
are Mr. Hunt's clients, and I won't say anything  
about them, but I'm sure they are excellent.

THE COMMISSIONER: What page is this,  
Mr. Scott?

MR. SCOTT: 15 of the report.

THE WITNESS: They are all very good.

MR. SCOTT: Q. Yes. And Mr. Cimbura,  
who, not a doctor, was there for toxicological  
purposes.







H.7

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A. Yes.

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Q. All of them have a level of suspicion that is substantially lower than yours, isn't it, they say very little suspicion?

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A. I wouldn't say substantially lower. I said suspicious and they say very little suspicion. But you have to remember that most of their impression was based on my findings, my clinical findings.

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Q. Well, they couldn't have been all that moved by it because you voted suspicious death and with you were Dr. Gilmour-Bryson and the Homicide team but you couldn't sway your colleagues?

14

15

16

A. Well, the main reason for that was because the toxicology was a problem here. I believe that there was some toxicology in Woodcock, I'm not sure.

17

18

THE COMMISSIONER: I think there was some but it was very faint.

19

MR. OLAH: Exhibit 95E, Mr. Commissioner.

20

THE COMMISSIONER: All right.

21

MR. SCOTT: Well, we will leave that.

22

THE COMMISSIONER: Are we leaving Woodcock?

23

MR. SCOTT: Yes.

24

25





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Hastreiter, cr.ex.  
(Scott)

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THE COMMISSIONER: Would this be a

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good time then?

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MR. SCOTT: Certainly, sir.

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THE COMMISSIONER: Well then, we will

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break until 2:30.

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--- Luncheon adjournment.

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---Upon resuming at 2:30 p.m.

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THE COMMISSIONER: Yes, Mr. Scott?

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MR. SCOTT: Thank you, Mr. Commissioner.

5

Q. Dr. Hastreiter, with respect

6

to the balance of the babies in this class, that  
is to say, Taylor, Shrum, Gage, Onofre, MacDonald,

7

Gosselin, did you have a chance, and I can quite

8

understand if you didn't, to read any of Dr. Rowe's

9

evidence with respect to these babies over the

10

weekend?

11

A. Yes, I read some of it.

12

Q. And therefore, I take it with

13

respect to some of them, at least, and I am just

14

trying to shorten this up if I can, you have some

15

knowledge of the hypothesis that he advances with

16

respect to the cause of death?

17

A. Yes.

18

Q. Can you tell me, and I ask

19

pleadingly in an effort to shorten this exercise,

20

if there are any of those babies in which you agree

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that his hypothesis was a reasonable one in the

22

circumstances?

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A. Well, I really don't remember

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the individual babies, you see, that is the problem,

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I can't ---





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Q. All right.

THE COMMISSIONER: That was a good try, Mr. Scott, but it is almost impossible.

Q. All right, let's begin then with MacDonald. MacDonald was a baby, you will recall, who was in the hospital for about twelve hours before he died. Dr. Rowe's evidence in Volume 14, at Page 2494 beginning on the previous page, and I would just read it to you, I think.

"Q. Now, the whole thing is a very rapid course, the baby is in the Hospital only a very short time, about twelve hours. Are there any particular matters in the record, Doctor, which you consider to be significant in our consideration of why this child died, when and in the manner that he did?

A. I think the most important issue is, one of a high probability, is that he had pneumonia, as judged by the chest x-ray and at least the suspicion of that, apparently, and the fact that at, was it 5:00, I have a note somewhere about 5:00 he started to have a lot of subcostal noisy







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2

respiration, subcostal breathing, 57/74.

3

I can't see where I had that, I looked

4

before at that."

5

And then at Page 2496 in the same volume at the top  
of the page:

6

"Q. Now I thought it was believed  
that -- it was suspected that the  
child had pneumonia?

7

8

9

A. Yes, I think that was because  
of the history.

10

11

Q. Yes. Was there any confirmation  
of that on autopsy?

12

13

A. Yes.

14

Q. Where do I find that?

15

A. Well, it is in the Preliminary  
Report. It says under Anatomical  
Diagnosis:

16

17

'Congestion in the lungs?

18

Bronchiopneumonia.'

19

Q. Forgive me, does that seem  
to be saying any more than the physicians  
had said during the life of this child,  
'Does this child have pneumonia?'

20

21

22

A. No, it doesn't, other than at  
least there is some suspicion in the

23

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pathologist's mind there is pneumonia.

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Q. As there had been in the clinician's  
mind?

4

A. Yes.

5

6

Q. Now, you referred then to the  
suspected pneumonia. Is there anything  
else that is of particular significance  
that should be borne in mind when con-  
sidering the death of this child?

7

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A. I think just severe failure, not  
responding well to medication and con-  
tinuing obvious signs of failure with  
a suspicion of pneumonia."

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Now, what I wanted to ask you is, is that a reasonable  
hypothesis to advance in the face of the death of this  
child some twelve hours in the hospital?

15

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MR. HUNT: If I could just comment on  
my friend's use of the word, "hypothesis."

17

18

MR. SCOTT: Diagnosis.

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MR. HUNT: My friend uses the word  
hypothesis, and it may become important. Before lunch  
my friend put to this witness the question of what  
he would do in his own hospital if he had to put  
forward a hypothesis on the day after the death of  
Laura Woodcock, and whether or not that would be the





1  
2 same, and the word used again is, "hypothesis", for  
3 Dr. Rowe.

4 MR. SCOTT: I would change the  
5 question.

6 MR. HUNT: I didn't say anything up to  
7 this point, but when Dr. Rowe was advancing hypothesis  
8 in this case, in many cases he has given it as his  
9 opinion, this is what caused the death, and there is  
quite a difference between the two.

10 Q. Well, Doctor, would you and  
11 I agree that confronted with the death of  
12 a child a doctor takes the clinical signs if  
13 he has them, the autopsy signs, and attempts to  
14 determine, if he can, first of all as a matter of  
hypothesis what the cause of death is.

15 A. Yes, but there are degrees of  
16 hypothesis.

17 Q. Of course.

18 A. And if it is really well sub-  
19 stantiated by the facts you call it a notional  
diagnosis.

20 Q. What do you have to say about  
21 Dr. Rowe's diagnosis in this case?

22 A. Look at -- I agree that this  
23 child had a large ventricular septum defect, congestive  
24  
25





1  
2 heart failure and that in a situation like this  
3 pneumonia could be an important complication.

4 I must admit, though, that I am a little  
5 bit confused when I look at the various reports and  
6 note in the chart about the severity of this pneumonia.

7 For instance, as you know, there are  
8 several notes that indicate questionable pneumonia;  
9 then there is an x-ray report, the chest x-ray which  
10 apparently does not describe any pneumonia. I think  
11 it is on Page 61 of the chart. The autopsy report  
12 grossly -- apparently the pathologist did not have  
13 any -- they indicated there was no gross consolida-  
14 tion of the lungs; but in the microscopic report  
15 is where they describe viral pneumonitis which is  
16 bilateral and confluent.

17 So putting everything together it  
18 becomes to me a little bit difficult to evaluate  
19 how much this pneumonia actually contributed to the  
20 child's death, if at all.

21 Q. Well, what is the criticism  
22 you have of Dr. Rowe's diagnosis?

23 A. Oh, I have no criticism of  
24 Dr. Rowe. I think that is probably the most  
25 likely explanation that one would resort to.

Q. All right. I take it your own







1  
2 evidence at Page -- Volume 77, Page 6879, you  
3 say when you are reviewing the case.

4 A. Which page again?

5 Q. 6879.

6 A. Okay.

7 Q. "Upon admission here, let's  
8 say, the chest x-ray showed that the  
9 heart was large and there was no evidence  
10 of pneumonia, which is often a  
11 complicating factor in an acute situa-  
tion like this."

12 So what I am suggesting to you is if you had known  
13 there was evidence of pneumonia, you might have  
14 drawn a slightly different conclusion about this  
15 child.

16 A. It is difficult for me to  
17 conceive the existence of severe pneumonia when the  
x-ray doesn't show it.

18 Q. No, but the autopsy report  
19 shows it, doesn't it?

20 A. That was later, that was some-  
21 what later.

22 Q. Yes, but I don't care whether  
23 it was later.

24 A. It makes a great deal of  
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difference, the timing is very important.

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Q. Well, the autopsy report didn't kill the child, what the autopsy report showed was pneumonia, didn't it?

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A. It definitely showed pneumonia.

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Q. Yes.

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A. Whether it was pneumonia severe enough to kill the child, I think is the very important question.

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Q. But your statement made the other day was that there was no evidence of pneumonia; now, it is not the end of the world, but what I am suggesting --

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A. On chest x-ray.

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MR. HUNT: Upon admission.

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Q. All right.

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A. Upon chest x-ray, the chest x-ray report does not indicate the existence of pneumonia, and the chest x-ray is very sensitive, it is, it is the best diagnosis one would have.

Q. Doctor, the record will speak for itself and I don't want to take you through your whole transcript unless necessary. Would you agree with me that in discussing this child last week, and the reason why you placed it on the list





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that you did, you made no reference to pneumonia  
at all, that is fair, isn't it?

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A. I knew that the child had  
pneumonia because I had reviewed the chart and the  
autopsy report was included in the chart.

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Q. Now, let's turn to Gosselin,  
and Dr. Rowe at Page 2530 in Volume 15, at 2530-31-32  
says this, and this is a question by Mr. Lamek.

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"Q. Did any cardiologist or Cardiac Fellow or any physician to your knowledge raise any question about the cause of death?

A. I think there were concerns about the suddenness of the deterioration and that was expressed by one or two people. I am not personally concerned about the explanation because this, in my view, was a very severe coarctation. The baby had, as I gathered, developed worsening of the failure during the evening from about 9 o'clock onwards and although there had been an initial response by diuresis, that simply demonstrates that we were skating on very thin ice with this baby and I think that I would ascribe progressive deterioration and failure to that. The question that other people had raised was that relating to prostaglandins.

Q. Yes.

A. There had been periods of apneic and there was some discussion..."







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I think that should be apnea.

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"...and there was some discussion I think in our conference about that point, whether or not this baby's death might have been induced by the prostaglandins."

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Then on the next page:

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Prostaglandins have an effect on the central nervous system of producing apnea and is a known complication of the administration of the drug. When it occurs, what is usually done is that the dose of the drug is reduced. In this situation the judgment was apparently made to continue at the same level of the drug because of the concern that there was not a good effect evident from the prostaglandin in opening up the ductus."

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I take it, Doctor, what do you have to say -- or I should ask you, what do you have to say about Dr. Rowe's diagnosis in the Gosselin case and the diagnosis of his clinic as it refers to the Monday conference?





BB3

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3 A. Excuse me just a second. I  
4 think that Dr. Rowe is right here. This is a very  
5 severe coarctation of the aorta and the baby clearly  
6 did not respond to prostaglandin very well. The  
7 reason I say this is because I think in Dr. Freedom's  
8 report, he indicated that there was a blood pressure  
9 difference between the arms and the legs following  
10 the institution of the prostaglandin treatment, which  
11 was quite significant, indicating that there was still  
12 very severe obstruction, and that the prostaglandin  
13 was not really helping this baby very much.

14 Q. Would you agree, then, that  
15 that diagnosis is appropriate in the circumstances?

16 A. Yes, I agree that the diagnosis  
17 is appropriate. Now, the question remains again  
18 whether or not the baby died because of that, and I  
19 would think that sometimes babies will die in a  
20 situation like this. I was again perhaps impressed  
21 by the rather abrupt change in the baby's status  
22 before the baby died.

23 Q. If this baby had died in your  
24 own hospital, would there have been any doubt in your  
25 mind of what the baby died of, I mean, any significant  
doubt. We never know for certain.

A. You know, it is a little bit difficult





Hastreiter, cr.ex.  
(Scott)

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to transport oneself to a different setting, different location.

Q. Well, just pretend you are looking at this record -- I am sorry.

MR. LAMEK: Mr. Commissioner, would Mr. Scott permit the witness to finish his answer?

MR. SCOTT: It is a habit.

MR. LAMEK: If I may say so, with respect, it is a very bad and disturbing habit.

MR. SCOTT: Well, that is a fair comment, I guess. I will reserve comment on the habits of others, but I apologize for it and I will try, Doctor -- you just hold up your hand if I interrupt you. That will silence me like nothing.

THE WITNESS: I would say that the possibility that this baby died from his or her heart defect and complications thereof exists, definitely exists.

MR. SCOTT: Q. Well, apart from a possibility, if the baby died in some hospital other than the Toronto Sick Children's Hospital, would there be any other significant possibility that you see in this record?

A. I think there's always a little doubt and this would have to do with the final,





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abrupt deterioration of the baby. But in all honesty, yes, I agree with you that this was a very sick baby and death was not really unexpected.

Q. Now, Taylor, at Volume 11, page 1850, Dr. Rowe is asked about this baby by my friend, Mr. Lamek, and Dr. Rowe begins at line 11 speaking of the death of this baby:

"A. Well, we would say perhaps sudden but not unexpected; not necessarily unexpected.

Q. Sudden but not necessarily unexpected.

A. No. Because the anatomy of the patient's condition would say to us, look, this is a very severe malformation and that baby is at risk to suddenly deteriorate.

Q. But I guess not at the time of the risk, being fully apprised of the baby's malformation, the suddenness of it may itself have been surprising, is that fair?

A. No, that is not fair, because this baby was recognized as having very severe left heart disease. The







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"electrocardiogram had what we call  
left ventricular strain. There was a  
suspicion of endocardial fibroelastosis  
and, under those circumstances, that  
baby, regardless of the additional  
details of -- "

And then there is an exchange.

"Q. In the light of what you from  
the chart, can see was known of this  
baby's condition at the time of the  
arrest, then, you will go this far with  
me, Doctor, that the arrest was sudden  
but not unexpected?

A. Yes. I think that is a fair  
description."

And then over at page 1863 at line 10:

"Q. And that, after a day and a  
half, when from the charts at least,  
it appears his condition had been  
stable, his vital signs stable, he had  
been feeding well, he had been lively  
and alert?

A. Yes.

Q. Is it not fair to say, Doctor,  
that in light of that immediate history





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"and the stability that has seemed to be achieved with this child that the onset of the terminal events and their rapid course and the death were not expected to occur when they did?

A. We get back to this problem of expected and unexpected death.

Q. When they did?

A. Yes. I have difficulty answering that because I would agree that there was a sudden deterioration, but whether one would say that was unexpected in knowing the anatomy of this baby and the severity of the problem involving the left ventricular and the speed with which the arrhythmia advanced into what was obviously ventricular fibrillation, in retrospect one would have difficulty in saying that was unexpected, but it certainly was sudden."

Now, what do you say about Dr. Rowe's diagnosis and his assignment of the cause of death of this baby?

A. Excuse me just a second. Again, I would certainly agree with Dr. Rowe that this





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3 baby had a very serious heart problem. Aortic stenosis  
4 is one of those that may produce sudden death. It is  
5 the one that is most likely, perhaps, to produce  
6 sudden death.

7 So, in general, I would agree, and  
8 that the baby had endocardio fibroelastosis, which  
9 really compromises the left ventricle and makes the  
10 situation worse. There were certain facts here,  
11 especially a notation in the chart which made it  
12 perhaps difficult to interpret what the real status  
13 of the baby was. For instance, the baby had a  
14 cardiac catheterization planned but it was not  
15 performed. Why was it not performed? It could be  
16 because the baby was too sick to do it. That is one  
17 possibility. But the other possibility would be  
18 that the clinicians were not so terribly concerned  
19 that the baby would die, so that they postponed it.  
20 They were trying to improve the baby before they  
21 performed this procedure.

22 There is a note by Dr. Heilbut saying  
23 that the baby had improved considerably on the day  
24 following the admission to the Hospital. Now, I  
25 understand that Dr. Rowe, in his testimony, indicated  
that he did not agree with Dr. Heilbut and that is  
very well possible. I do not know how experienced Dr.





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3 Heilbut was.

4 Q. Well, she was a resident.

5 A. Yes. Then there is a note by  
6 Dr. Arluk, A-r-l-u-k, I believe, stating that the  
7 baby was alert and did not appear distressed. There  
8 is a note by Dr. Izukawa where he indicated that he  
9 reviewed  
10 /the medications for the possibility of an overdose  
11 or error, so he must have been concerned with the  
12 problem.

13 The type of arrhythmia that this baby  
14 developed is a type of arrhythmia that one would  
15 expect with digitalis overdose.

16 Q. Doctor, if I can ask you this:  
17 if this death had occurred in your hospital and you  
18 were being asked to review the record, what would you  
19 have said was the cause of death, bearing in mind  
20 no one is ever certain?

21 A. I think I have now learned the  
22 answer to your question. It is a difficult question  
23 to answer, and I was not there, so that makes it  
24 very difficult. But the real, I think, key is how  
25 it happened, whether it happened all of a sudden,  
unexpectedly and so forth, and no matter how well you  
extract this information from the chart and talk to  
various persons, it is not always -- you know, you do







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3 not get a complete picture.

4 I would say it is a matter of probabili-  
5 ties again. I think, yes, this baby could very well  
6 have died because of his original disease. However,  
7 I am not sure that he should have died at that very  
8 time when this occurred, you know.

9 Q. Doctor, as a cardiologist, you  
10 are not infrequently asked to review the records of  
11 babies who you have not seen; is that not so?

12 A. True.

13 Q. And I take it that you have  
14 to, from time to time, if you are invited, make a  
15 diagnosis from that record; is that not so?

16 A. Yes.

17 Q. You have seen the records that  
18 come to you for this kind of purpose from, no doubt,  
19 a number of hospitals?

20 A. Right.

21 Q. And that is what you were  
22 being asked to do here?

23 A. Yes, but the question that is  
24 asked varies from case to case, and the decision here,  
25 the question that you are asking me is whether his  
heart problem was enough to cause the baby's death  
at that particular time. This is perhaps, you know,





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3 one of the most difficult questions.

4 Q. The question I am asking you,  
5 Doctor, is very simply this: if you got this record  
6 from a hospital and it was not Sick Children's  
7 Hospital, because this was long before Baby Cook died,  
8 I take it there would be no substantial doubt in your  
9 mind about why this baby died and that you would share  
10 Dr. Rowe's opinion?

11 A. I think I already indicated  
12 that I share his opinion to a great degree. There  
13 remains a little question as to the timing of the  
14 baby's death.

15 Q. Is there anything in his  
16 opinion that you think is not given significant weight?  
17 Before you answer the question, let me see if I can  
18 just explain the problem.  
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You have very candidly to Mr. Lamek said that one must, looking back over the events, be careful that one's judgment is not clouded by subsequent events and that is a difficult exercise for all of us and that is why I suggest to you that you might be able to help us if you could say now, look, if I saw this record from some other hospital I would agree with the cause of death by and large that has been assigned to this baby; in other words, we can take it away from Sick Children's for a moment where we know what happened, the murder trial and all the rest of it, and look at it as you have to do as a hospital record. I suggest to you that it would not be unfair to say that you basically agree with the assessment of cause of death that Dr. Rowe on this record has come to?

A. Well, you had asked me earlier if I agree with everything Dr. Rowe says about this particular child and I agree with everything except for one thing and, that is, I cannot exactly determine from his comments what the baby's condition was, was the baby improving or not, because there is a fair amount of contradiction, you must admit yourself from reading the notes from different physicians. I would value Dr. Rowe's opinion more





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than that of the others but this is where it is  
difficult to resolve.

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Q.

If you were looking at this  
record and it came from Detroit Hospital, let's just  
change the name on the top of it to Detroit Hospital,  
is there any other diagnosis on this record which  
is possible on the basis of reasonable probabilities?

A.

Any other diagnosis as far as  
the baby's cause of death?

Q.

Yes?

A.

Immediate cause of death is  
concerned?

Q.

Yes.

A.

You know, you have, as in  
everything else in this field, it is a matter of  
probability really. You have to say how certain  
can you be that this was the only cause of the baby's  
death.

Q.

If this record came to you from  
Detroit Hospital what other cause of death would you  
want to consider, apart from the one Dr. Rowe has  
given?

A.

I don't see what difference it  
would make where that baby came from. Certainly I  
would not suspect digitalis overdose per se.







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Q. All right, that's fine. You wouldn't have any reason to at Detroit. What other cause of death would you give as worth considering if it came to you from Detroit, or is this the only one?

A. If I had the complete information, let's say from autopsy and everything else and there was no evidence, let's say that the baby had not developed pneumonia, aspirational pneumonia, had not received an accidental overdose of the medication, these are all possibilities that one would have to be a little bit careful in ruling out and, you know, if I were satisfied that this condition had been excluded then I would say yes, the baby died of his natural condition.

Q. Well, let me just be perfectly clear. If this chart came to you, as charts do, from a place like Detroit, is there any other diagnosis that on this record you would consider as being more than a mere possibility?

A. Not on this record, no.

Q. All right, thank you very much.

Now, can we come to Shrum. I'm going through the same exercise here and if at any stage you can shorten it up by telling me in advance that





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you are with me we will shorten it up..

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A. Yes.

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Q. Have you read what Dr. Rowe has  
to say about his diagnosis of this baby?

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A. Yes.

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Q. Yes. And just to take you to -  
I will summarize it simply by reading from Volume 11,  
page 1904, at line 21:

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"Q. Right. Doctor, are you satisfied  
on the basis of your view of this case  
that Baby Shrum's death and the time  
and manner of his death are entirely  
consistent with the nature and extent  
of his cardiac illness?

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"A. I am."  
Now, if this baby's chart came to you  
from Detroit Hospital would there in your opinion be  
any evidence to support a diagnosis other than the  
one that Dr. Rowe has made?

19

A. Excuse me just a second.

20

Q. Yes, yes, take your time, please.

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A. Well, I think this is a baby  
that we had discussed at some length earlier with  
Mr. Lamek and the baby had had a cardiac catheterization,  
went back to the floor and died several hours later.





CC.5

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Q. Yes.

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A. And I think that in all fairness

4

this is not a terribly unusual situation for a baby

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to develop a problem like this following a very

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significant insult or procedure like a cardiac

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catheterization, a great deal of stress and so forth.

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I was, if you remember, a little concerned about the

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fact that the baby developed this somewhat unusual

10

arrhythmia, complete heart block several hours later,

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not at the time of the cardiac catheterization but

several hours later.

12

Q. Yes, I remember that.

13

A. And this perhaps will be a little

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difficult to explain. But I would say that all in

15

all I would not argue, you know, very much in support

16

of any other reason for this baby's death. I think

17

that the baby could very well have died of

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complication of the cardiac catheterization, of

natural cause.

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Q. And I take it that if it came

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to you from another hospital there would be no

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substantial doubt about that diagnosis?

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A. No, I don't think so. I would

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be, you know, as careful as I could, especially with

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regard to this arrhythmia.

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Q. Yes. And is the only thing that you question the fact that the block occurred some three hours rather than immediately following the catheterization?

A. That to me is the main source of concern, yes.

Q. Yes. That wasn't a matter that concerned Dr. Fay at all, was it?

A. I don't remember.

Q. Yes.

A. I really don't know whether he indicated that or not.

Q. Yes, or Dr. Bennett or Dr. Tepperman.

A. I wouldn't know, I don't remember.

Q. Well, let me ask you to turn to your vote at Exhibit 261. Do you have that up there?

A. Yes, I think so. Page 11?

Q. Yes. Have you got that there?

A. Yes.

Q. I note that Dr. Fay says not very suspicious but cannot rule out, Dr. Bennet says low suspicious, Dr. Tepperman says low suspicious, that hawk Mr. Cimbura says natural. You even lose Dr. Gilmour-Bryson who says low suspicious and you







CC.7

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and apparently a police officer are with suspicious death.

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MR. YOUNG: That is not altogether accurate, Mr. Commissioner. We are talking about Baby Shrum. There are eight police officers that voted for suspicious death and four others that indicate natural death.

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MR. SCOTT: Were they all in the room?

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MR. YOUNG: It says at the beginning of the minutes, Mr. Scott, exactly who was there and I invite you to look at that.

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MR. SCOTT: Well, some must have come in because there weren't 12 police officers there.

14

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Q. Were the police officers coming in and out of the room?

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A. No.  
THE COMMISSIONER: I took it that they had had a preliminary vote.

18

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THE WITNESS: Yes, they had had a preliminary vote.

20

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MR. SCOTT: Before they heard the doctors on the subject?

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THE COMMISSIONER: That is what I understood.

23

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MR. SCOTT: Oh, I see. Well, all right.





CC.8

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Q I take it in any event, Dr.

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Hastreiter, that the feeling of the moment was that

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the other doctors weren't prepared to share the level

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of suspicion that you had in the case of the Shrum

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baby?

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A Well, perhaps I should review

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with you the mechanics of this meeting and how it  
was conducted.

9

Q If you want to.

10

A First, I would present the

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clinical evidence. Most of my diagnosis was made, at

12

least my initial diagnosis was made on that basis.

13

Then the others would come in. Dr. Fay, Mr. Cimbura

14

with the toxicological information and so forth, and

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then we would sort of pool our opinions. I was

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always the first one to indicate my opinion and

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following my opinion there may have been some

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discussion there between the others, among the others,

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and this is not reflected in the minutes. This is

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why you will see that my opinion is quite frequently

a little bit different.

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Q Tougher, yes.

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A For most of the others.

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Q Was the vote at the end of the

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discussion?

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CC.9

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A. Well, the vote was at the end of the discussion but following each person's opinion there was additional discussion, you know, between my vote and Dr. Fay's vote there probably was some discussion and then after Dr. Fay's vote there was more discussion and so forth. So that things - perhaps one would tend to go more one way or the other. I don't think there is such great difference.

Q. Maybe not.

A. Between suspicious and --

Q. Do I understand then that the votes were given in sequence before you had heard the others' opinion, is that what I have?

A. No, no. First one would hear everybody's opinion then one would vote and then between my vote and the others' votes there would be additional discussion.

Q. So, Dr. Fay, Dr. Bennett, Dr. Tepperman had the benefit of your opinion before they voted, is that right?

A. Oh, yes.

Q. Yes. And you were able to listen to what they said, is that right?

A. Yes.





CC.10

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Q But you didn't change your opinion as a result of what they said?

A I don't think I usually did but it made no difference because my opinion was not the one that would determine the final decision. The final decision was Dr. Bennett's really and I think it was his vote that really counted. So, as long as he had it there was no reason for me to change mine or to add anything.

Q So, really, it was Dr. Bennett's opinion that governed, as you understood it?

A Yes, that was my feeling because he was the authority there.

Q All right. Well, I'm not quite sure I understand what was going on but maybe I never will.

A I think it is the type of decision that the coroner would have to make in Chicago.

Q Well, let's turn to the Gage child, the Gage baby.

A Yes. Perhaps I should add that in some of these cases I may very well have changed from suspicious to low suspicious but there would be no point in my indicating it since Dr. Bennett







CC.11

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had already voted and his vote was low suspicious,  
to add mine would really be just a waste of time.

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Q Well, let's test that out. In  
the Shrum case are you now prepared to change that  
to low suspicious?

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A. Yes.

7

Q All right.

8

A. I would.

9

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Q And would it be fair to say that  
you would change to low suspicious or you would  
change to a lower vote in those cases where the  
majority of medical doctors favoured a lower vote?

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A. No, I cannot say that.

13

Q All right.

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A. I would have to look at each  
case individually.

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Q Well now, on Gage, Dr. Rowe  
gave evidence about this case, as did Dr. Freedom,  
and Dr. Freedom's evidence is at Volume 28, page 5320,  
first of all reports on his letter to the referring  
doctor and then at page 5322 he deals with what he  
found at post mortem.





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A. I am sorry, which one was this?

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Q. Volume 28.

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A. I think I probably have it.

5

MR. HUNT: No, I have it here.

6

What were the pages again, please?

7

Q. And 5322, Line 10:

8

"Q. Was it your view that the only gross post mortem findings supported the explanation of an hypoxic episode as the likely cause of death?

10

11

A. Correct."

12

Then he explains that. Then at 5324 he says, he is asked about the fact, about the record, and he says:

13

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"Q. And we know, Doctor, at least from the progress notes, bearing in mind your evidence as to the severity of the child's condition, that immediately prior to its death its respiratory status was described as stable with no distress. Is that correct, doctor?

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A. Again on the third line -- excuse me, the second line after nursing notes it says, 'Colour was pale but not cyanosed.'

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I think it is not uncommon to see a baby and describe him as pale. As a matter of fact, most parents even when they know a baby is blue they will not call him blue. They will call him pale because of the slate grey colour that many of these babies have.

So on that one note, you know, where it says no respiratory distress, I take it for what it says. But I note the same day that the baby was retaining carbon dioxide at 55, so to me that cannot mean that this baby was comfortable and stable.

Q. Directing your attention specifically to respiratory changes as opposed to the colour of the child, Doctor, am I correct that immediately prior to the episode which led to his death it appeared that his respiratory condition was stable at that point?"

And he refers to the note. The answer at Line 17:

"A. They described the baby's respiratory rate between 76 and 62.

Q. Yes.





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A. And that is very fast for a --

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I am sure it is much faster than for

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a normal baby, and to me again that would

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be commensurate and compatible with a

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baby that is working hard, that is

7

breathing too fast, and perhaps one that

8

is going to tire out."

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And then he goes on. Then he says, he sums it up

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at 5327, at the top:

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"Q. Do I take it correctly, then,

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Doctor, that in your opinion both the

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clinical symptoms exhibited by this

14

child prior to death and the post

15

mortem findings at least at gross

16

autopsy was supported and indicative

17

of an hypoxic episode as the likely

18

cause of death?

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A. Yes."

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And then Dr. Rowe at Volume 13, Page 2191 says,

21

after commenting on a possible renal failure, which

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is set out in the notes, and the record says at Line

23

16:

24

"A. The problem that confronted

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the physicians at that time was that

they were hoping --"







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2 MR. HUNT: I'm sorry, what page was  
3 that again?

4 MR. SCOTT: 2191.

5 MR. HUNT: Thank you.

6 Q. "The problem that --"  
7 After dealing with the renal difficulty:

8 "The problem that confronted the  
9 physicians at that time was that  
10 they were hoping to be able to control  
11 the congestive failure better than they  
12 did, as it turned out, and the reason  
13 for that was that they wanted to get this  
14 baby a little older and a little bigger  
15 so they could do what is known as an  
16 arterial switching operation. That  
17 is an operation that repairs a  
18 malformation truly and takes the great  
19 arteries and puts them back where they  
20 should be.

21 That was the alternative to the  
22 operation that eventually was planned  
23 and in order to do that the baby has  
24 to be a little bigger.

25 So, I think for a while, Dr.  
Olley and the others involved in the care





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thought this baby might, we might be taking advantage of the situation while the kidneys are recovering, hopefully, to give us a little more time to manage the heart failure. But it looks as though he's not so pleased about things."

Then at Page 2210, Dr. Rowe is at Page 60 of the record, and this is at Line 6:

"At Page 60 it is recorded, two-thirds of the way down the page, under the heading CHF, congestive heart failure, slightly improved, continued dig. and dieuretics, discussed possibility of surgery of ligation of PDA which although is causing mixing of blood which is need is also keeping her in CHF, and that is the paradox of this child's management, is it not, at this stage?

A. That is the paradox ---

Q. That's the paradox about this child's management at this stage?

A. Yes I would have thought then that the evidence would be for the duct to have been closing but clearly there was a problem with mixing





and heart failure."

Now, Doctor, you have heard what Dr. Freedom and Dr. Rowe have had to say about the cause of this child's death being its natural condition, and I ask you again, assuming this record came to you from a Detroit hospital, would that be a diagnosis that you would accept as reasonable on the balance of probabilities?

A. Excuse me a second. I think again in general I would agree with Dr. Rowe's comments, but there are a few questions that would remain, though. For instance, the blood gases are, especially the pO<sub>2</sub>, arterial pO<sub>2</sub>, are the best indicators as to how well the baby is progressing, whether the balloon septostomy that the baby had was successful or not. Dr. Rowe claims that basically it was not because the baby is not mixing blood sufficiently and support.

Now, let me see, the baby had this procedure performed on the 5th of September, and the last blood gas I have here before the baby's -- there is one on the day prior to the baby's death, but then there is a ten day gap when no blood gasses were available that I could find. This to me sort of indicates that if they were so terribly





1  
2 concerned about the baby's hypoxia, or hypoxemia,  
3 actually, the amount of oxygen in the blood, they  
4 should have measured the blood gases through this  
5 period perhaps more frequently. That was one  
6 of my concerns. The last one that is listed here,  
7 which was -- I mean -- yes, the last one where a  
8 pO2 is available, because in the one obtained  
9 just prior to the baby's death there was no pO2  
10 available, and the value of that pO2 was 43. Now,  
11 43 is not great, but it is not very bad, either, it  
12 is sort of an acceptable level.

12 Q. I don't want to interrupt you  
13 because I get in trouble if I do. If this record  
14 came to you from a Detroit hospital, is there any  
15 other diagnosis for the cause of death that you would  
16 suggest on this record as being available?

16 A. I think I will have to continue  
17 to explain my reason, I won't take very long, but I  
18 do feel that there are a couple of questions that  
19 need to be framed. The other problem here was the  
20 problem of the renal failure, the baby developed  
21 an acute renal failure immediately, or shortly after  
22 this cardiac catheterization. Then they waited  
23 with the surgery, observing the baby. The baby-- they  
24 had to give the baby some time for the renal failure  
25







1  
2 to heal, which apparently it did, at least to a very  
3 great extent, and if they were so terribly concerned  
4 about the baby's situation, why did they wait so  
5 long to operate on the baby, that is my other question.

6 So if I want -- the operation was  
7 scheduled, I think for the 25th and the baby's  
8 cardiac catheterization had to be done on the 5th,  
9 so there is a 20 day interval, that is a long time  
10 for a little baby of whom one is so worried about.  
11 So in answering your question I think babies do die  
12 of this problem, but they should not, they really  
13 should not. You should try to prevent them from dying,  
14 that is what they are here for. And yes, I would have  
15 had some doubts about why, you know, they let it go.

16 Now, to come up with another diagnosis,  
17 that is almost sometimes an impossible task. If the  
18 baby came from Detroit, and if there is no additional  
19 information available, I couldn't come up with  
20 any other diagnosis.

21 Q. That is what I am getting at.  
22 I take it on this record there is no other diagnosis  
23 possible, is there?

24 A. No, but see, that is with  
25 the information available from this record, but  
all information may not be in this record, that is





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the ---

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Q. No, but you want to take into account the way the Cook baby died six months hence, don't you?

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We are way back, I think, in September now and what I am saying to you is if you look at this record and surely it is not so difficult if you look at this record in isolation, or indeed in September, there is no other diagnosis that you can suggest at that time apart from the one that Dr. Rowe and his colleagues have suggested, is there?

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A. You know, I am trying to think of a comparison, but you do have a big gap here, you have a ten day interval where you have no laboratory data that would be extremely helpful to me, and to perhaps the other clinicians to make this evaluation that you are asking me to do. So there is a big piece of information that you are missing and without this information you want me to reach a conclusion which you know it is not easy to reach.

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Q. On this record, what is the alternative diagnosis?

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A. Well, with the information available on this record, there is probably no alternative diagnosis, but ---





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Q. Thank you, all right.

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A. All the information -- he interrupted.

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MR. LAMEK: All the information is not available in this record, I want to make that clear.

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Q. I want to suggest --

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MR. HUNT: Perhaps on a question of clarification, dealing with this, my friend continues to say in isolation, is the doctor left to consider the deaths that have gone on before, each death, I appreciate he cannot consider the ones that occurred after, is he asked to treat each one in strict isolation or whether there is sort of a cumulative effect here after the number of deaths occurred in July, August and September.

15

THE COMMISSIONER: Well, I don't know.

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MR. SCOTT: I wouldn't even get into this exercise if everybody would concede that there is no complaint about the diagnosis from case to case that Dr. Rowe and Dr. Freedom made.

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THE COMMISSIONER: But they made those diagnoses -- now, they made the diagnosis here.

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MR. SCOTT: Yes.

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THE COMMISSIONER: In this court room.

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MR. SCOTT: Dr. Rowe, you will recall, Mr. Commissioner, said to you that if it was demonstrated that Cook was murder, I guess we shouldn't use the word murder, that then there were I think he said 7, 6, 7 or 8 babies that he would want to very carefully look at, you will recall him saying that.

THE COMMISSIONER: That is right.

But the real problem, I think is that the rules changed in your cross-examination from what Dr. Rowe said. Dr. Rowe was allowed to use everything he wanted including the charts.

MR. SCOTT: Yes.

THE COMMISSIONER: All the knowledge that he had.

MR. SCOTT: Yes.

THE COMMISSIONER: And he reached these conclusions that he gave to us.

MR. SCOTT: Yes.

THE COMMISSIONER: But you are not allowing Dr. Hastreiter quite the same latitude.

MR. SCOTT: No.







EE/BN/ak

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3 You are saying that he must look at the documents and  
4 he must, from those documents, find that only,  
5 whereas what he wants to do -- well, I do not know  
6 whether he wants to do it or not, and he can correct  
7 me if I am wrong, but he wants to be able to look  
8 at everything, look at all the children that have  
9 been there, look at the readings of toxicity that  
10 have been discovered in some of the babies and then  
11 reach his conclusion accordingly.

12 MR. SCOTT: Dr. Rowe has said that  
13 he believed that the Baby Cook received a massive  
14 overdose, a killing overdose of digoxin.

15 THE COMMISSIONER: That is right.

16 MR. SCOTT: And he said if that  
17 assessment is correct, I would look suspiciously at,  
18 and he gave the names of a number of babies.  
19 Dr. Hastreiter has said exactly the same thing. What  
20 I am concerned to do is look at it from the other  
21 perspective, that is to say, as these babies died,  
22 was the assessment that the doctors made at the  
23 Sick Children's Hospital --

24 THE COMMISSIONER: At that time, yes.

25 MR. SCOTT: -- at that time a  
legitimate, reasonable, fair assessment, or is  
somebody going to say in September you misdiagnosed





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this case. If my friends tell me that nobody is going to say that, and I suspect they may not, but if that is out of consideration, I will stop. But it seems to me my obligation, and so far there has been no substantial disagreement on it, that if you look at these cases as they occurred, the diagnosis made is at least the acceptable diagnosis. Looking back on it, you may think Dr. Rowe's opinion that eight of them are suspicious, with hindsight, is the right one.

THE COMMISSIONER: Well, I am not sure that I fully understand what you are doing, because if you are merely trying to establish that the diagnosis put on the deaths of these children at the time they died or after the autopsy or something like that is a reasonable, in fact conceivably the only reasonable diagnosis, why then do you read what Dr. Rowe says now? Why do you not just simply read from the autopsy or read from something that was contemporary with ---

MR. SCOTT: Because Dr. Rowe did not participate in the autopsy and Dr. Rowe did not make, in every case or indeed in many cases, a note that is part of the record. What you have for cause of death on the record, as you know, is the presiding





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3 clinician's opinion and the pathologist's opinion,  
4 if there was one, expressed in the autopsy report.

5 One of the reasons Dr. Rowe was  
6 called was to give that. Now, if there is no doubt  
7 about that ---

8 THE COMMISSIONER: Well, I must be  
9 very careful because not everybody agrees with what  
10 I conceive to be my duty in the report, but I would  
11 have thought that all I have to do is say what is  
12 the cause of death, based upon all of the information  
13 that I have, not whether you made a good diagnosis  
14 at the time or not. I might throw that in gratuitously,  
15 which would please you to no end, but I do not even  
16 know that I have to concern myself with that.

17 MR. SCOTT: I do not think you  
18 have to, and if I had the assurance of everybody  
19 that you did not have to, I would stop now.

20 THE COMMISSIONER: I doubt if you are  
21 going to get a unanimous assurance out of this  
22 particular body. So, carry on. But at least now we  
23 know what you are trying to establish, and if I can  
24 just suggest to you, Doctor, that when these questions  
25 are put to you, I think, as I now understand it,  
but Mr. Scott, you correct me if I am wrong, what he  
is after now is not whether you agree with Dr. Rowe's





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present  
/opinion as whether you agree that that was a perfectly  
reasonable diagnosis at the time of the death of  
the child. Have I correctly stated that?

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MR. SCOTT: Yes.

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THE COMMISSIONER: If the matter  
is rephrased that way, you might find it easier to  
answer.

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THE WITNESS: Yes, that was not  
very clear to me, because as I indicated earlier,  
I have great regard for Dr. Rowe, Dr. Freedom and  
everybody, and in all these cases that we have  
covered so far there has never been a misdiagnosis  
of any consequence that I can see at the time, the  
diagnosis made at the time of the baby's death.

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MR. SCOTT: Q. I am going to get  
both of us out of here in time for this coffee  
break with one question.

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THE COMMISSIONER: All right.

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MR. SCOTT: Q. You have looked at  
all 36 records, have you?

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A. Yes, I believe -- no. How  
many did you give me? You gave me a list and there  
were some checked. I do not remember how many there  
were.

Q. Fifteen, I am sorry.







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A. Fifteen I believe, yes.

Q. You looked at 15, and those are the ones for which you made -- there is more than 15 there.

Well, let us take it more broadly. You looked at all the babies' records for whom you were asked to give a numbered evaluation of the cardiac seriousness?

A. Yes.

Q. And that certainly covers enough. Did you detect, in examining those records, any diagnosis that you judged, judging it at the time the diagnosis was made, to be erroneous or questionable?

THE COMMISSIONER: Well, he is going to have a hard time giving you a monosyllabic answer to that one because he has been dealing with several of them in which he has expressed a difference from the present view and the present view is the same as the old view. For instance, take the case of Hines and SIDS, and that is one example that comes immediately to mind.

MR. SCOTT: No, Mr. Commissioner. Hines was a case that Dr. Rowe said would have to be examined in the light of Cook.





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THE COMMISSIONER: All right. Well then, perhaps that is a bad example. I should let the witness answer that one, if he can.

MR. SCOTT: Q. Do you understand the question, Doctor?

A. I have reviewed these 15 cases, as you had asked me to, but I still believe that we should perhaps -- I would say there are no gross differences as far as diagnosis at the time, but there are -- you know, we are dealing with subtle differences here, and sometimes it could be significant, I am not sure.

THE COMMISSIONER: Are you satisfied with that?

MR. SCOTT: No.

THE COMMISSIONER: What do you think? I know ---

MR. SCOTT: I have one more case after this.

THE COMMISSIONER: And you then want to bounce off.

MR. SCOTT: And I will be finished. Do you want to take a break? There will be time.

THE COMMISSIONER: There will be time?





Hastreiter, cr.ex.  
(Scott)

EE7

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MR. SCOTT: Yes.

THE COMMISSIONER: You can do it?

MR. SCOTT: I promise you. Now,  
I join in that promise with Dr. Hastreiter, who has  
to help me so that I can keep this promise.

THE COMMISSIONER: He has to give  
you a certain answer. Well, I cannot promise his  
co-operation, but you have to leave precisely at 4:00?

MR. SCOTT: No, I do not have to  
leave at 4:00. You know, 4:15 or 4:20.

THE COMMISSIONER: I see. Then  
there is no reason why we cannot take our break now.

MR. SCOTT: No.

THE COMMISSIONER: We will take 15  
minutes.

---Short recess.

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---Upon resuming after the recess.

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THE COMMISSIONER: Yes, Mr. Scott.

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MR. SCOTT: Yes.

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Doctor, just to sum it up on Gage, again, the vote is contained at Page 11 of Exhibit 261. I take it that Dr. Fay, Dr. Bennett and Dr. Tepperman and Mr. Cimbura voted either minimum suspicion in one case or a low suspicious in three, isn't that right?

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A. Yes.

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Q. And you and Dr. Gilmour-Bryson vote suspicious death.

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A. Right.

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Q. Yes. Again, I suggest to you that your suspicions didn't carry the day at that meeting.

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A. Yes, there was a difference in degree, I believe, that prevailed.

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Q. All right. Well, now, let's come to the last case with which I want to present to you and that is the case of Onofre. This you will recall was the baby who had a small shunt. If I could take you first to -- it is quite a long passage but I think it is important. Dr. Rowe's evidence in Volume 14 at Page 2478. I am going to read







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2 it, but to summarize it, I think this is the case  
3 where Dr. Rowe said that the staff were surprised at  
4 the moment the baby died but they formed an opinion  
5 as to the cause of death on the basis of certain  
6 autopsy material. It begins at Line 19 on that page:

7 "O. Were you satisfied that this  
8 death, including the time and the  
9 manner of onset and progress of the  
10 terminal events, was consistent with  
11 the physical condition and the  
12 clinical condition of this  
13 child?

14 A. I think we were just surprised  
15 at that particular moment. We were not  
16 surprised when we got all the rest of  
17 the information."

18 "We were not surprised after we got  
19 all the information from the autopsy.  
20 I think it was thought at the time  
21 that the most likely explanation for  
22 the death was that the arrhythmia  
23 that had been apparently benign all  
24 along became more significant."

25 "The other explanation, following the  
autopsy information, was that there were





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features there that could account for the baby dying, the sepsus which was extensive, and I am not sure exactly when that information came through, and the small size of the shunt. There was a 2 mm. orifice which was much smaller than you would hope for, so that hypoxia and sepsus might have created the arrest. These are conditions that can produce findings of this sort."

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And then at Page 2480 at Line 18:

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"Q. Is there anything in the preliminary autopsy report that caused you, upon seeing it, to say, okay, now we know what caused this child's death? What did you know after seeing this preliminary report that you didn't know before?

19

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A. I think we knew the size of the shunt was small.

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Q. You did not know that before?

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A. We did not have that information during life."

And then down to Line 17:





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"Q. Would that have provided a  
different explanation from the one that  
you might have arrived at before  
seeing --"

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And Dr. Rowe interrupts just like I do:

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"A. Yes, I think so.

8

Q. In what respect?

9

A. I think that would confirm that  
the amount of blood going through that  
shunt was extremely small, so the hypoxia  
might have triggered, in a patient  
that had arrhythmia, a more important  
disturbance.

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Q. Anything else in the autopsy  
report that provided you with information ---

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A. The banding necrosis just strengthens  
the question of whether or not the  
arrhythmia might have been related to  
muscle damage.

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Q. When this information became  
available, what was your understanding  
of what that finding involved?

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A. The finding of muscle banding?

22

Q. Yes.

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A. That would imply damage to muscles

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which caused the arrhythmia.

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Q. Without knowing the extent of  
the damage, it would be very difficult  
to --

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A. And to a portion of the septum.  
It would not have to be very much.

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Q. It would be hard to include it  
as a causal development in this whole  
thing, unless you had rather more  
information than appears from this,  
would it not?

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A. We have clinical information  
that is unusual in that this baby,  
who had a tetralogy malformation was  
having arrhythmia --

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Q. Yes.

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A. -- from the time it arrived  
and that is an unusual finding in  
tetralogy of Fallot with pulmatresia.  
We know, in patients who die with  
tetralogy of Fallot after surgery, in  
infancy, there is damage of a type to  
myocardium. The exact cause of this  
is uncertain but it is thought to be  
some reduction in blood supply to the

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superficial layers of the muscle inside the right ventricular, and it has been postulated by others that this type of condition in certain babies with tetralogy of Fallot may be responsible for the mortality after surgery. Now, that is as far as one can go. We cannot be absolutely sure which effect predominated here, but my view is that there are a number of factors operating, each of which might have, on its own or together, created the situation that arose here."

And then Dr. Freedom's evidence at Volume 29, Page 5372.

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A. I'm sorry, what was the page?

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Q. 5372.

16

A. Thank you.

17

Q. Dr. Freedom was the doctor

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who did the catheter on this baby.

19

A. Yes.

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Q. At Line No. 7:

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"A. So, I felt we had a baby with two problems, two congenital problems; one was the severe heart disease, as you have outlined, and two, that he

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had, for some reason, a most stable,  
initially ventricular dysrhythmia.

I even wrote, and this is on Page 66."  
And he refers to his consultation note of November  
22nd:

"A. Correct, that I considered that  
the ventricular dysrhythmias could be  
transient, could be associated with  
tumours and the like. So, I was  
concerned about how this baby presented.  
The next day we do the catheter study  
and we find in addition the severe  
heart disease. That sort of litany  
was throughout this youngster's  
chart.

He did undergo successful  
surgery in the sense that the surgeon  
was able to construct a shunt and  
the baby survived. Our newborn results,  
at this time, suggested a mortality for  
a newborn shunt in the range to 25%.  
So, I was initially pleased that this  
baby survived.

Q. Yes, Doctor, but the rest of  
his course, you know, was not as





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comfortable. He had wound infection

3

on November 2nd --"

4

This looks to me as if this should be the answer

5

here. Ms. Cronk isn't here.

6

"He had wound infection. On December

7

2nd we noted continued ventricular

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irregularity on his cardiogram, by

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December 7th we considered that he had

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necrotizing enterocolitis, an inflam-

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mation of his intestines with bloody

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stools at that time and I think again

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in a baby that is ill, who has undergone

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surgery, any infection or inflammation

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of the intestines can be extremely

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serious.

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A day later there was discharge

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from his wound and throughout that whole

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time we were concerned, at least in the

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last several days, we were concerned

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about his oxygenation.

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At the time of his arrest on

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the 9th he had an extremely low

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oxygen level of pO2 of 15. They

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found virus in his stool and so I felt

this was a debilitated baby with





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2 structural heart disease, with a  
3 ventricular dysrhythmia which is  
4 quite uncommon in my experience in a  
5 baby, in a newborn with heart disease  
6 who died as a result, probably, of  
7 inadequate shunt and ongoing systemic  
infection."

8 Now, Doctor, those are the opinions of the clinician  
9 and Dr. Rowe reviewing the record and I want to ask  
10 you if at this time those opinions were given, and  
11 leaving aside digoxin, there was any other likely  
12 diagnosis for the death of this child?

13 A. Excuse me just a second, please.

14 Q. Yes.

15 A. No, I think I would agree  
with their opinions in this case.

16 Q. Well, now, can I ask you, Doctor,  
17 to turn to Exhibit 261, which is the meeting of  
18 September 13th, 1982.

19 A. Yes. I'm sorry, what page again?

20 Q. 13.

21 A. 13, okay.

22 O. Now, you and Dr. Gilmour-  
23 Bryson voted probable murder and I understand  
24 probable murder to be your designation that this  
25







1  
2 case requires some further investigation. Have I  
3 got it right?

4 A. Yes, that's it.

5 Q. All right. What was it in the  
6 case that in your opinion required further investiga-  
7 tion, or do you recall?

8 A. I will get to it in just a  
9 second. Let me just find the right page here. Yes,  
10 again, the unexpectedness, perhaps, of this child's  
11 death and the abruptness of the death appears to be  
12 somewhat striking. This baby had been admitted on  
13 the 22nd, had the surgery performed on the 24th of  
14 November and died on the 9th of December; that is  
15 a good two weeks later.

16 The baby appeared to be reasonably  
17 stable, at least from a cardiovascular standpoint.  
18 Granted that he had these gastrointestinal  
19 problems. He had blood in his stools, he had an  
20 infection, possibly necrotizing enterocolitis.  
21 It wasn't very clear, though, that this baby, that  
22 this was enough reason to kill the baby. With  
23 regard to the baby's stability, again, if you look  
24 at the laboratory data you will find that following  
25 his surgery he had blood gases performed up until  
about the 13th of November and from then on there is





1  
2 only blood gas, I think a couple of days before  
3 his death, but that does not include areterial pO<sub>2</sub>,  
4 which is the most important one if one is concerned  
5 about the hypoxemia, or lack of oxygen in the blood.

6 As far as the arrhythmia is concerned  
7 it never struck me as being a very serious problem,  
8 at least not from reading the chart. It could be,  
9 but it was not the impression I had when I read  
10 the chart, at least there didn't appear to be a  
11 great deal of concern about this arrhythmia. So then  
12 all in all we don't have a real good explanation, at  
13 least we don't have one single explanation for the  
14 baby's death. We may have a composite of a number  
15 of things here, like, hypoxia, infection, GI problems,  
16 arrhythmia and so forth which all put together  
17 could cause the baby's death and I think that certainly one  
18 has to be concerned, but I felt that we should look  
19 further into this situation.

20 Q. Let me ask you this and  
21 perhaps -- the evidence of Dr. Rowe and Dr. Freedom  
22 is not confined to the cardiovascular evidence. It  
23 paints a picture of a child that had difficulties,  
24 multi-system difficulties, would that be fair?

25 A. Yes.

Q. Yes. Both of them had given





1  
2 their opinion, made at the time, that the baby  
3 expired from those multi-system difficulties. Now,  
4 do I understand your observation to be, first of all,  
5 that you are concerned about the unexpectedness  
6 or the suddenness, whatever those words mean?

7 A. Yes. And I can tell you what  
8 the words mean because this baby was said to be  
9 reasonably stable and this is what I would call  
10 unexpectedness, and the suddenness, I think, is the  
11 abrupt onset of this terminal event.

12 Q. That in your view, coupled with  
13 your opinion that the record doesn't disclose that  
14 these multi-system difficulties were so serious.

15 A. I think, yes, you are right.  
16 Individually, taken individually they were not  
17 serious enough to explain the baby's death, but  
18 placed together, of course, it is always difficult  
19 to evaluate a situation like this when you have  
20 multiple problems and it could very well have been  
21 responsible.  
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Q. I wouldn't for a moment ask you to consider them separately. I take it in looking at cause of death you are obliged to try and consider them as a group, are you not?

A. Yes, but in medicine this becomes a very difficult problem when you - what the physician usually tries to do is find one - focus on the main problem, and try to find one single problem that could explain the events. Now, if you don't have that, and here in a postoperative situation this is often the case where you have infection, the child apparently had a wound infection in addition to what I just said, a GI problem and the arrhythmia and so forth, then it becomes a much, much more difficult problem to interpret and to ---

Q. I'm sorry, are you finished?

A. Yes.

Q. Dr. Freedom at Volume 29, page 5385.

A. Yes.

Q. This is just a short passage and I could read it to you.

A. Okay.

Q. "You were not surprised that he died when he died?"







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"A. No, I think again reading the chart fully and seeing the ongoing concern about infection, bloody stools, this baby was very ill and I am saddened for the baby and the family but I think his demise was consistent with the multi-system problems that this baby had."

Now, I take it that you don't --

MR. HUNT: Perhaps there was a distinction between Dr. Rowe and Dr. Freedom with respect to the sudden and unexpected nature of the baby's demise.

MR. SCOTT: I have read what Dr. Rowe said.

MR. HUNT: I don't think you read what he said about --

MR. SCOTT: Well my friend can read what he would like to read.

MR. HUNT: Except two days from now it is difficult to come back to this.

THE COMMISSIONER: Take the invitation as it Mr. Hunt goes to you now.

MR. HUNT: All right, I can't argue with that. It is Volume 23 and it is at page 4225.









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MR. SCOTT: Let me just get it please,  
the page please?

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MR. HUNT: 4225.

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MR. SCOTT: Yes.

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MR. HUNT: And it starts at line 8:

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"Q. Dr. Rowe, John Onofre died on  
December the 6th at 4:15 a.m., and am  
I right that your view is that this  
death was not only sudden but unexpected  
as well?

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A. I have on my notes 'sudden (?)  
unexpected'. That was on the 9th of  
December, yes.

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The reason that I queried the unexpected  
issue was simply that he had an  
arrhythmia and he had sepsis as it  
later turned out. But the issue was  
arrhythmia, the implication of the  
arrhythmia at the time.

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Q. So that gave you some question  
with respect to the unexpected nature  
of the death?

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A. No, I think the arrhythmia was  
the question of whether that had  
initiated the suddenness of the death,

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"perhaps unexpected. Perhaps I should concede that.

Q. I was just going to say perhaps there is at least some doubt about it?

A. Yes."

MR. SCOTT: And reading on, because this is exactly the parallel to what I read in the beginning:

"Q. So based on that, again, are we not - I should not say again, but are we not dealing here with the case that would appear to fall squarely within one of the conditions set out in the Coroner's Act for reporting?

A. Yes, it would. We, I guess, took the position that the patient had a severe malformation and known arrhythmia and might have died at any time. We obtained a post mortem and confirmed that and had even more information."

Now, Doctor, I forget where I was, but that happens.

What was the point you were making of all that, Mr. Hunt? It is precisely what I have







GG5

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2 read at 2478.

3 MR. HUNT: I think it is a little  
4 clearer in this example that there apparently was  
5 a disagreement between Dr. Freedom and Dr. Rowe with  
6 respect to the nature and the unexpectedness --

7 MR. SCOTT: Q. No, the evidence of  
8 Dr. Rowe that I read you in the beginning,  
9 Dr. Hastreiter, said that when the baby died we  
10 perceived it to be sudden and unexpected. Then when  
11 we got the autopsy report we were able to draw  
12 conclusions about why the baby died. Did you under-  
stand that to be Dr. Rowe's evidence?

13 A. It is not clear to me whether  
14 what Mr. Hunt read occurred before or after this  
15 statement here; what you just read was earlier?

16 MR. HUNT: It occurred, in timing  
17 the actual evidence occurred after but he was referr-  
18 ing to the point in time when the baby died, he  
19 concedes that it was sudden, it was a sudden and  
unexpected death.

20 THE WITNESS: Yes.

21 MR. SCOTT: Q. Well, let me begin  
22 again what I read from the beginning. Doctor, can  
23 I take you to Dr. Rowe's evidence, Volume 14 at  
24 page 2478, and I am not going to read this out loud,  
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3 but I am going to ask you again to read beginning  
4 at - to yourself, beginning at line 19 over to the  
5 bottom of 2479.

6 A. Yes.

7 Q. Now, sir, have you finished  
8 reading that?

9 A. Yes.

10 Q. And I take it that what  
11 Dr. Rowe is giving as his opinion is that when the  
12 child died, at the time the child died, he perceived  
13 the death to be sudden and unexpected; but when  
14 other information, including autopsy information  
15 became available he found that there were features  
16 that could account for the death, isn't that right?

17 A. That is what I understand.  
18 Could I ask again what Mr. Hunt read, was that later,  
19 was that later in the transcript?

20 MR. HUNT: Was his evidence given  
21 later, yes, it was.

22 THE WITNESS: It was. So you see it  
23 more or less contradicts a little bit what you said.

24 MR. OLAH: With the greatest respect,  
25 Mr. Commissioner, Dr. Rowe's evidence is on the record  
and to have this witness interpret his evidence really  
doesn't assist us, it speaks for itself.





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MR. SCOTT: The problem has been created. Mr. Hunt has asked me to read and has read a passage of the evidence which is exactly the same as page 2478;

"When the baby died we believed it to be unexpected and sudden, then we got autopsy information..."

Is that what you say the evidence amounts to, Mr. Hunt?

MR. HUNT: The point I was making was the evidence you just read with respect to Dr. Freedom was not in accord with this evidence which I read, which was to my recollection much clearer than what you read earlier.

MR. SCOTT: All right, let's deal then with Dr. Rowe. In both passages he has agreed that when he first saw the death he believed it to be sudden and unexpected. But after the autopsy he concluded that it was supportable.

Q. Now, what I want to get from you, because he may return to give evidence, is any areas of disagreement you have in respect of his assessment at that time.

A. You see the whole question here evolves around the expectedness and the





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abruptness of the death of this child. Okay.

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My understanding is this, that before the autopsy this was the case, Dr. Rowe agreed that death was unexpected, abrupt. After the autopsy he felt that an explanation had arisen and he could explain it better. Although I am not so sure what Mr. Hunt read really very clearly states that.

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Q. No, it doesn't, but don't worry about it.

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THE COMMISSIONER: I wonder if we could just assume for purposes that is what Dr. Rowe did say, assume he did say he was --

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THE WITNESS: Okay.

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THE COMMISSIONER: He was surprised, he found it unexpected or sudden at the beginning but after he read the autopsy it became clear.

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MR. SCOTT: Q. I have read to you Dr. Rowe's account why his diagnosis and Dr. Freedom's account of his diagnosis, what I want to get from you is bearing in mind the time at which they are made I take it that those are the only reasonable diagnoses of this death that could possibly be made at that time.

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A. I think that is a very reasonable assumption.

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Hastreiter, cr.ex.  
(Scott)

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Q. And at that time you couldn't think of any other diagnosis that you could make?

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A. That is correct.

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Q. And then when you came to the vote at the September 13th meeting and you voted it "probable murder", I take it what you were focusing on was the sudden and unexpected nature of the death, primarily?

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A. That is correct.

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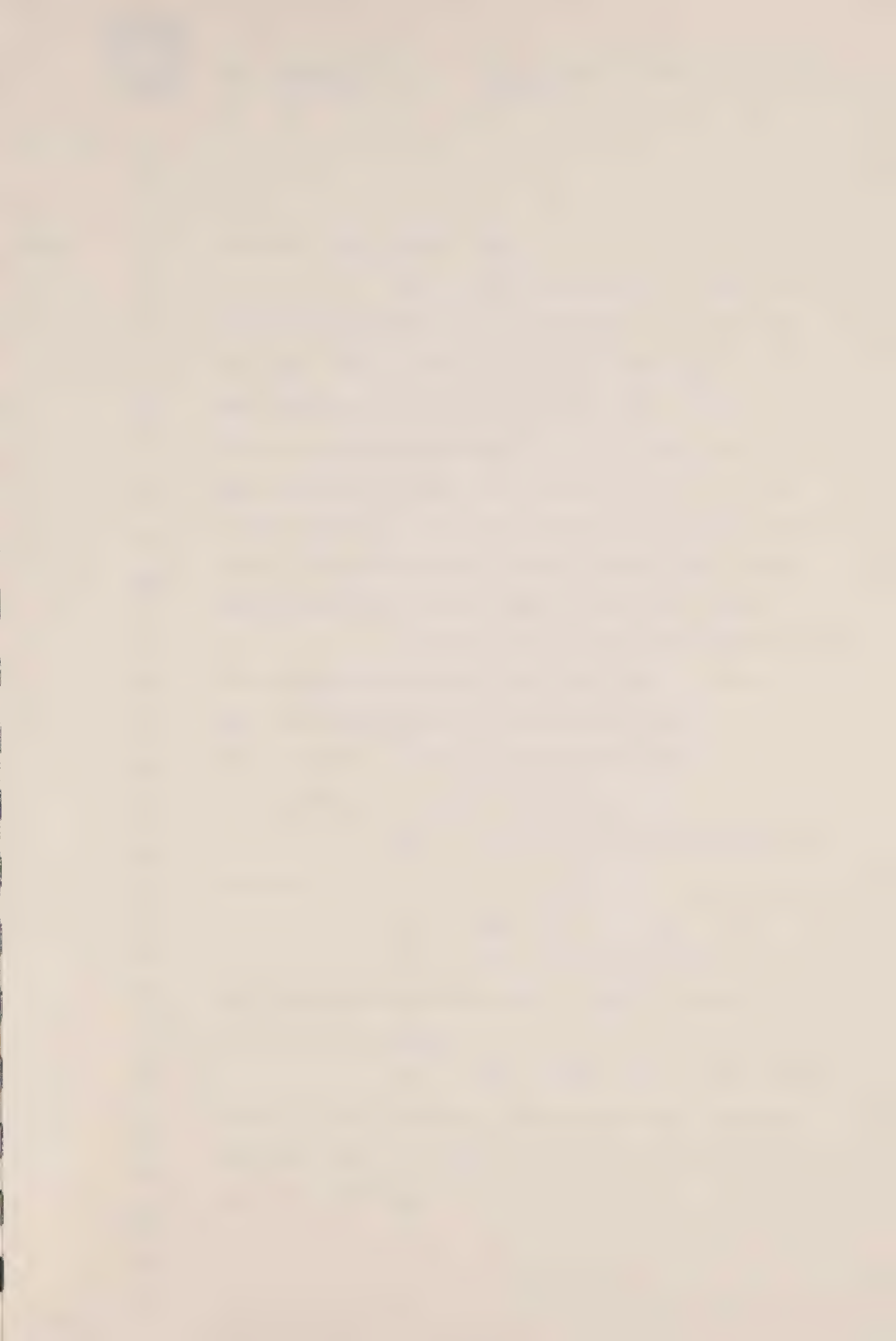
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Q. And would you agree with me that if you analyzed the autopsy evidence and the clinical course as Dr. Rowe and Dr. Freedom have done, that that analysis may offset the suddenness and unexpectedness of the death?

A. Well, I think here is where we come to a disagreement, because like everything else it is a matter of probability, and I think everything Dr. Rowe said and Dr. Freedom said I find quite reasonable, but I don't find that the probability that this occurred is that high. In other words there is still a gap of information there that could be their explanation, but may be a different explanation, and this doubt is what led me to categorize this child in that particular group.

Q. What information would you









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like that you haven't got?

A. The following: I would like to know why is it that Dr. Lichtman for instance just one hour before the child died he had seen the child and said: "Baby was stable the IV had come out". And he was called apparently to reinsert the IV. There is, two hours later, he was called for the cardiac arrest, and he was obviously surprised about that. There are several other notes in the chart that state that the baby was relatively stable.

I would like to know why if they really were concerned that the shunt was small, why was there not - why were there not additional blood gases drawn between - from the 30th of November to the 7th of December.

Q. Dr. Hastreiter, I read you the evidence of ---

A. Yes.

Q. --- of both Dr. Freedom and Dr. Rowe who said they didn't know the shunt was small until autopsy.

A. Oh, but you do, you do, because there is some clinical information which tells you that the shunt is small, and that is exactly the low pO<sub>2</sub>'s in the blood.





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Q. All right, what else would you like to know, because I am just making a list so we can get this information?

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A. I think I would like to know more about the arrhythmia, and was this really a reason for concern, because it was not my impression from reading the chart that there was a great deal of concern.

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Finally I would like to know two more things: actually one would be the infection, and how well this was documented, and whether this GI problem which maybe one cannot separate from the problem of infection, how much that was.

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So I understand that we are dealing again with a composite with a group of factors here which could very well have killed the baby, I am not disputing that by any means, but what the probability rating here is is a completely different question.

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Q. Just so I will have it to review, apart from digoxin is there any other diagnosis possible in this baby's case?

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A. Apart from digoxin?

Q. Yes.

A. Here listed?

Q. Yes.







GG12

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A. No, I don't believe so.

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MR. SCOTT: Thank you for your  
patience, Doctor, very much, I have done exactly as  
promised.

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THE COMMISSIONER: Yes, all right.

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I think we will take a poll though. Mr. Ortved, how  
long do you think you will be?

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MR. ORTVED: I think I will probably  
be about no more than half an hour, probably less  
than an hour, Mr. Commissioner.

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THE COMMISSIONER: Miss Jackman?

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MS. JACKMAN: I still expect to be  
half an hour.

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THE COMMISSIONER: Mr. Olah?

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MR. OLAH: Somewhere in the range  
of about an hour to an hour and a half.

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THE COMMISSIONER: Mr. Labow?

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MR. LABOW: At this point,  
Mr. Commissioner, I would expect about an hour and  
a half.

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THE COMMISSIONER: Mr. Shanahan?

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MR. SHANAHAN: Mr. Shinehoft has  
indicated he will be half an hour to 45 minutes; and  
I will be about 15 to 20 minutes.

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THE COMMISSIONER: Mr. Tobias?

MR. TOBIAS: I would think about half an hour to 45 minutes, Mr. Commissioner.

THE COMMISSIONER: Well, I do not think we will make it tomorrow, and I think that will tell you something about your plans. I would like to complete Dr. Hastreiter before we have our argument. So, it may be either Wednesday afternoon or Thursday morning, I would think. Does that seem reasonable? What are you going to do about another witness or are you just going to think about it?

MR. LAMEK: Mr. Commissioner, if we do not get to argument of the motion, the application for a stated case until Thursday morning, perhaps I may ask you if we can defer another witness until Tuesday following Dr. Kauffman on Monday next week? I may deal with it that way.

THE COMMISSIONER: You have not asked me yet, though.

MR. LAMEK: No, I may ask you.

MR. SCOTT: If we could teach Dr. Hastreiter to sit down, he would be more comfortable.

THE COMMISSIONER: Well, I think Dr. Hastreiter likes standing.





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THE WITNESS: I prefer standing.

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THE COMMISSIONER: Yes. Yes, Mr. Tobias?

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MR. TOBIAS: Yes, Mr. Commissioner, I am not sure that a great deal turns on it, but something that Mr. Scott said just prior to the break was the subject of some discussion between myself and Mr. Young and to a lesser extent Mr. Lamek. Just for the purposes of the record, I would like to clarify it.

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I thought my friend to be suggesting to the doctor, in putting questions to him, that it was Dr. Rowe's evidence that if indeed, as he suspected, the Cook baby had died from an overdose of digoxin, then there were six or seven others who he would put into the highly suspicious category. If you will look at Volume 18, I believe that more accurately stated, the evidence of Dr. Rowe was that unquestionably Cook's death was related to an overdose of the drug digoxin, and because of that, he had to look at the six or seven others somewhat more carefully. But I do not think there was any question in his mind at that time about the likelihood of the Cook case.

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THE COMMISSIONER: Yes.

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MR. SCOTT: I did not mean to convey that there was. It is all on page 3275.

THE COMMISSIONER: Yes, Miss Forster?







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MS. FORSTER: Mr. Commissioner,  
Mr. Lamek was good enough to provide us with a copy  
of Dr. deSa's report this morning. In skimming it  
over, it appears that Dr. deSa gave the CDC additional  
material other than the report, and in particular, at  
page 24 he talks about including material on some  
kind of a survey done at the Winnipeg Hospital  
regarding clustering. I was asking Mr. Lamek through  
you, sir, whether it would be possible to provide us  
with that other information?

THE COMMISSIONER: It is something that  
perhaps is in the files of the Atlanta people when  
we have them.

MR. LAMEK: It may be. I have not  
seen that material, Mr. Commissioner, but I'll  
inquire about it.

THE COMMISSIONER: We will try and  
track it down.

MS. FORSTER: Thank you.

THE COMMISSIONER: Anything else?  
All right, then, until 10 o'clock tomorrow morning.

--- Whereupon the Hearing adjourned at 4:30 p.m.  
until Tuesday, December 13th, 1983, at  
10:00 a.m.







